

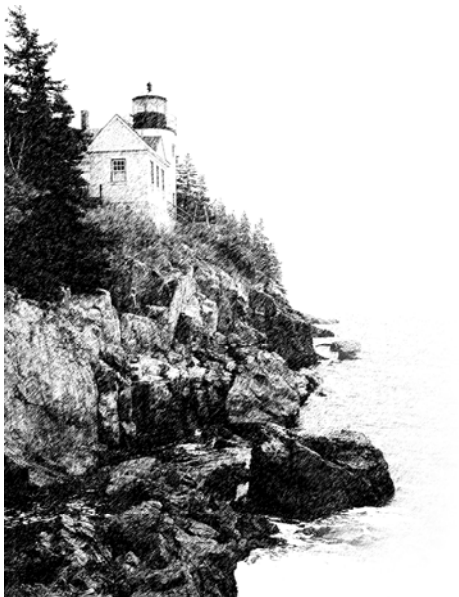
September  
2007

# **State of Maine Department of Audit**

Special Report to  
The Joint Standing Committee  
on Health and Human Services

## **Medicaid and State Children's Insurance (SCHIP) Programs**

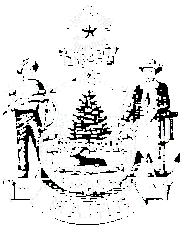
For the Period Ending  
June 30, 2006



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RE: Audit of Medicaid and the Children's Insurance Program for Fiscal Year 2006

Dear Chair Brannigan, Chair Perry, and all Honorable members of the Committee:

I am pleased to present you this report on our audit of Medicaid and the State Children's Insurance Program (SCHIP) for state fiscal year 2006. The Maine Department of Audit examined 26 major federal programs in total as part of our Single Audit of fiscal year 2006. Our audit covered programs that represent 89% of the \$2.8 Billion in federal assistance that Maine received during that fiscal year. The Medicaid Program accounts for an enormous share of that federal assistance: Medicaid spending, both State and federal dollars, was over \$2 Billion in 2006. In presenting you with the highlights of our audit, and in consideration of the special emphasis that you are placing on Medicaid, I chose to focus on these two important programs alone.

However, they are just two of the fifteen programs receiving federal assistance that are administered by the Maine Department of Health and Human Services. This report aims to help you understand the depth and breadth of our audit of Medicaid and SCHIP, as well as the skill and abilities of our auditors. I have asked the Medicaid audit team for 2006 to accompany me, and we will try to answer any questions that you may have following the presentation. Please remember that we would be happy to return to report on the other programs that we audited that are under your jurisdiction. In addition, we are available to research questions specific to your interests to the fullest extent possible.

Sincerely,

State Auditor, JD, CIA

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# Executive Summary

## 2006 Medicaid and SCHIP Audits

Medicaid –  
\$2 Billion program  
64% federal funds

SCHIP –  
\$33 Million program  
76% federal funds

Planning –  
Risk Assessment  
Audit efficiency

We met with many  
program managers

We went to regional  
offices

We audited Medicaid and the Children's Insurance Program as part of the State Single Audit for fiscal year 2006. Our audit serves to verify that funds appropriated by the Legislature are accurately accounted for, expended for the programs and purposes intended, and have effective controls in place to ensure compliance with laws and regulations, both state and federal. In addition, it satisfies federal audit requirements associated with the State's expenditure of federal grant awards.

Medicaid is a \$2 billion program, funded 64% by federal funds. Medicaid is the largest program administered by the State.

SCHIP is a \$33 million program, funded 76% with federal financial participation

We assessed the risk associated with the Medicaid program as high due to its size, its complexity and the number of internal control and compliance issues identified in prior audits. Because Medicaid and SCHIP are administered by many of the same people, share information technology systems, are both health insurance programs and because clients may be eligible for one or the other, we achieved audit efficiency by assigning the audits of both programs to the same team of five very experienced auditors.

Our work required us to meet with staff and test systems throughout the Department of Health and Human Services. We met with accounting and program managers in Financial Management Services, the Director of Internal Audit, the Office of MaineCare Services, the DHHS Division of Audit, the Program Integrity Unit, the Division of Purchased Services, the Office of Integrated Access and Support, the Fraud Investigation and Recovery Unit (FIRU), the Rate Setting Unit and Licensing & Regulatory Enforcement. We spoke with the Office of Fiscal and Program Review. Our examination took us to regional offices in Augusta, Bangor, Portland and Lewiston to examine client case files and to review business operations.

We traced  
electronic payments

We saw private  
contractors and  
providers

We tested  
electronic  
information systems

MECMS  
MMDSS  
EIS  
ACES  
WELFRE  
MACWIS

We tested claims  
data

We consulted  
legal counsel

We traced payments to electronic data submitted by Medicaid providers. We went on-site at Goold Health Care to examine the prescription drug payment processes and interfaces with eligibility and payment systems. We contacted pharmacies throughout the state to confirm that they had supporting documentation that drugs paid for had been prescribed by a physician and were dispensed and billed appropriately. We also obtained detailed records from MR Waiver providers to confirm services provided.

We accessed multiple DHHS information systems including MECMS, MMDSS, EIS, ACES, WELFRE, and MACWIS. We tested the system to system integrity of client eligibility data. We include flow charts on eligibility data systems and payment data flows.

We worked with Department of Administrative and Financial Services employees in the Office of Information Technology to address system interface issues, the sufficiency of documentation and understanding of processes and controls. We worked with the Health and Human Services Service Center and the Office of the State Controller on many accounting and financial reporting issues. We confirmed with Maine Revenue Services (MRS) the process and proceeds resulting from the Service Provider Tax and also the transition of eligibility determination for Maine Rx and Drugs for the Elderly from MRS to OIAS.

We tested claims data and client count information provided to the Deloitte actuaries. We found errors in the data provided, and our work was used to ensure a more accurate actuarial valuation of the Medicaid liability for Incurred but Not Reported Claims. We also met with Deloitte accountants and consultants on Interim Payments and estimates of the associated bad debt. We worked with other DHHS consultants and contractors, including CNSI and XWave to validate reported amounts and processes.

We consulted with the Office of the Attorney General, Medicaid Fraud Division, and FIRU legal counsel. We met as well as with the Assistant Attorney General for General Government and DHHS legal counsel for Medicaid.

We confirmed data

We contacted and confirmed or obtained information and/or data from the Department of Corrections, the USM Muskie Center, the Regional Administrator for Social Security Administration, the Centers for Medicare and Medicaid Services, and the regional Inspector General for Health and Human Services.

## Conclusions

We found many of the areas that we tested to be accurately reported, to have sufficient internal controls and to be in compliance. Those areas are not identified in this report other than as noted in the preceding procedures section.

MECMS not functional

We identified material noncompliance for each program that caused us to issue a qualified opinion for each. The Medicaid program does not have a fully functional claims management system; also, we could not obtain documentation to support payment rates established for the Home and Community Based Services Medicaid Waiver. The State Children's Insurance Program had significant eligibility error rates, which resulted in a qualified opinion.

HCBS waiver rates insufficiently documented

SCHIP eligibility error rate concern

Potential Cost savings:  
Medicare Part B  
Cost of Care deductible  
Pharmacy payment

We found areas that could result in potential cost savings. As we have discussed these with the Department, they may have already initiated action to realize savings. For example, Medicare Part B coverage was paid for individuals not eligible to be paid for by Medicaid. The Cost of Care deductible was not subtracted from payments to nursing home providers, thereby increasing the cost to the State. The State's payments to pharmacies did not ensure that payment did not exceed the usual and customary charges.

HCBS waiver improper billing

Our testing of payments to Waiver providers found that one provider billed early for services provided and one over billed – MECMS edit and limit checks did not prevent either.

We recommend:

SURS and FIRU  
support

Improve electronic  
eligibility systems

Specifics are in  
each finding  
summary

We noted that the Program Integrity Unit has been understaffed and that little to no Medicaid recipient fraud testing is being done.

A major area of concern is inadequate controls over Medicaid/SCHIP eligibility. We found that systems interfaces cause ACES to have different eligibility determinations than result in MECMS eligibility determination tables. Clients may be paid from the wrong program. System reports do not agree. We found that all required income eligibility verification cross-matches were not being done and that one such data exchange repeatedly reopened cases closed by caseworkers.

We have included summary information of the results of our testing. The summaries indicate the amounts questioned due to noncompliance and the areas in which we found noncompliance. The detail of each audit finding is included. We have also included a flowchart of information systems that we prepared to assist in planning our audit. OIT has since prepared a more detailed overview of IT systems.



## 2006 Summary of Medicaid and SCHIP Audit Findings

No.	Federal Program	Description	Activities Allowed	Allowable Costs	Cash Management	Davis-Bacon Act	Eligibility	Matching, Level of Effort, Earmarking	Period of Availability	Procurement and Suspension and Debarment	Program Income	Reporting	Subrecipient Monitoring	Special Tests	Known Questioned Costs	Likely Questioned Costs
1	Children's Insurance SCHIP	Estimated expenditures reported										✓				
2	Medicaid Cluster	Over billing of Waiver costs	✓												\$130,912	undeterminable
3	Medicaid Cluster	Insufficient claims payment controls	✓												\$12,173	undeterminable
4	Medicaid Cluster	Financial Accountability-Payment rates	✓												undeterminable	undeterminable
5	Medicaid Cluster	Unallowable targeted case management charges to Medicaid	✓	✓											\$27,870	\$10,600,000
6	Medicaid Cluster	Medicare Part B eligibility	✓				✓								\$112	\$1,186,020
7	Medicaid Cluster	Unallowable Waiver transportation costs	✓											✓	undeterminable	undeterminable
8	Medicaid Cluster	Unallowable vocational and social services	✓											✓	undeterminable	undeterminable
9	Medicaid Cluster	Prescription co-payment not charged and amounts overpaid for	✓												\$8	\$251,141
10	Medicaid Cluster	IT policies and controls inadequate	✓	✓			✓									
11	Medicaid Cluster/SCHIP	Eligibility controls inadequate	✓	✓			✓					✓			\$5,111	\$5,141,774
12	Medicaid Cluster	Cost of Care not deducted from payments to nursing home providers		✓											\$117	\$3,575,587
13	Medicaid Cluster	Inadequate control system over multiple authorized rates		✓											\$23	\$503,957
14	Medicaid Cluster	Lack of procedures to address Medicaid recipient fraud		✓			✓							✓		
15	Medicaid Cluster	Re-determinations not timely		✓												
16	Medicaid Cluster/SCHIP	IEVS data exchange noncompliant					✓									
17	Medicaid Cluster/SCHIP	Client eligibility determinations incorrect and differing between					✓									
18	Medicaid Cluster	MaineCare client counts inconsistent and not replicable					✓									
19	Medicaid Cluster/SCHIP	OMS unauthorized approval of non-timely filing						✓								
20	Medicaid Cluster	Third Party Liability collections										✓				
21	Medicaid Cluster	Medicaid financial reports do not satisfy requirements										✓				
22	Medicaid Cluster	HCBS Waiver annual report data can not be verified										✓				

## 2006 Summary of Medicaid and SCHIP Audit Findings

No.	Federal Program	Description	Activities Allowed	Allowable Costs	Cash Management	Davis-Bacon Act	Eligibility	Matching, Level of Effort, Earmarking	Period of Availability	Procurement and Suspension and Debarment	Program Income	Reporting	Subrecipient Monitoring	Special Tests	Known Questioned Costs	Likely Questioned Costs
23	Medicaid Cluster	Incorrect coding of crisis intervention services										✓		✓		
24	Medicaid Cluster	Inadequate follow-up in cases of possible fraud												✓		
25	Medicaid Cluster	Program integrity and surveillance and review												✓		
26	Medicaid Cluster	Claims processing and information retrieval system deficient												✓		
27	Medicaid Cluster	Inadequate security controls in Oracle Financials												✓		
28	Medicaid Cluster	Noncompliance with ADP review requirements												✓		
29	Medicaid Cluster	Individual Care Plan authorized services incomplete												✓		
30	Medicaid Cluster/SCHIP	Medicaid prescription drugs and supplies												✓	\$11	\$329,009
31	Multiple programs	Inadequate cost allocation plan		✓											undeterminable	undeterminable
32	Multiple programs	Inadequate controls over allocated cost journals		✓											\$2,129,301	undeterminable
33	Multiple programs	Inadequate controls over federal matching requirements						✓							undeterminable	undeterminable
34	Multiple programs	Inaccurate SEFA reporting										✓				
35	Multiple programs	Inadequate controls over federal cash management			✓											
36	Multiple programs	Inadequate controls over the administration of federal funds	✓		✓							✓				
37	Multiple programs	Inadequate support for the federal cash transaction reports (PSC-272)										✓				
38	Multiple programs	Excess working capital		✓											\$15,800,000	\$15,800,000

<b>Total</b>	<b>11</b>	<b>10</b>	<b>2</b>	<b>0</b>	<b>7</b>	<b>1</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>8</b>	<b>0</b>	<b>11</b>	<b>\$18,105,638</b>	<b>\$37,387,488</b>
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### Information Systems Audit Findings

3 Insufficient claims payment controls

10 Information technology contracts insufficient and IT policies and controls inadequate

12 Cost of Care not deducted from payments to nursing home providers

16 State Income and Eligibility Verification System (IVES) data exchange noncompliant

17 Client eligibility determinations incorrect and differing between systems

18 Reported client counts inaccurate

25 Controls do not ensure adequate program integrity and adequate surveillance and review

26 Claims processing and information retrieval system deficient

27 Inadequate security controls in Oracle Financials

28 Noncompliance with Automatic Data Processing (ADP) review requirements

Note: Equipment and Real Property Management and Real Property Acquisition compliance areas are not listed as there were no findings in these categories.

# CLIENT ELIGIBILITY DATA FLOW

DHHS Client Data from Eligibility Systems to Payment Systems, September 2006

**Intake/Application Data: (1) through (5):**  
(1) Personal Information, name, SSN, DOB, etc.  
(2) Financial Information, income, assets  
(3) Non-Financial Information, age, household, etc.  
(4) SSA/SSI Client Status, recipient or beneficiary.  
(5) Disability Assessment, if applicable.

**AUDITOR NOTE:**  
**AFDC Criteria:**  
**Maine State Plan for AFDC,**  
dated 7/16/1996  
Criteria is the Basis for many  
Family Related MaineCare  
Eligibility based on AFDC  
eligibility.

New England Child  
Support Enforcement  
System (NECSSES)  
Owner: OIAS

**OTHER EXTERNAL SYSTEMS:**  
Two-Way Interfaces or One-Way  
Data Transmissions  
Owners:  
IEVS (SSA, IRS); DOL, DMV, IFW,  
DMR, etc.

**AUDITOR NOTE:**  
**AFDC Criteria:**  
**Maine State Plan for AFDC,**  
dated 7/16/1996. Criteria is  
the Basis for some Title IV-E  
eligibility requirements.

Maine Automated Child  
Welfare Information  
System (MACWIS)  
Owner: OCFS

**Intake/Application Data: (1) through (5):**  
(1) Personal Information, name, SSN, DOB, etc.  
(2) Financial Information, income, assets  
(3) Non-Financial Information, age, household, etc.  
(4) SSA/SSI Client Status, recipient or beneficiary.  
(5) Disability Assessment, if applicable.

Automated  
Client  
Eligibility  
System (ACES)  
Owner: OIAS

EPPIC:  
*Electronic Benefits  
Transaction (EBT)*  
TANF & Food Stamps  
Owner: OIAS

EIS:  
*Adult Mental Health  
Tracking System*  
Owner: OAMHS

MeCARE:  
Long Term Care  
Assessment Tool  
Owner: OMS

MECAPS:  
*Managed Care System*  
Owner: OMS

MaineCare Point of  
Purchase System  
(MEPOPS): *Pharmacy  
Payments*  
Owner: OMS

ImmPACT:  
*Immunization Registry*  
Owner: OMS

WELFRE:  
*Legacy/Welfare System:  
Bull Interface System*  
Owner: OIAS

Medicaid Management  
Information System (MMIS):  
Maine Claims  
Management System  
(MECMS)  
Owner: OMS

Maine Medicaid Decision  
Support System (MMDSS)  
*Transaction Retrieval System*  
*Inactive since 1/2005*  
Owner: OMS

DATA WAREHOUSE  
*USM-MUSKIE Institute*  
*AD-HOC Transaction  
Retrieval System*  
Owner: OMS

## IT PROCESS: ACES Client Eligibility Determination for the Major DHHS Programs.

(1) Typically, client information is initially entered directly into ACES by OIAS caseworkers to determine what major DHHS programs an individual may be eligible for. Information from other DHHS systems, such as NECSES, and other external IEVS (Income & Eligibility Verification Systems) transmissions from the SSA, IRS, and DMV are added to this data in ACES and the eligibility process is "run" in ACES.  
(2) For some SSI related cases, however, eligibility is determined automatically in ACES resulting only from externally received client data transmissions.  
(3) Data pertaining to client eligibility status is sent to **WELFRE** for recipient aid category (RAC) code assignment.

## IT PROCESS: MACWIS Client Eligibility Determination for Title IV-E and Other Office of Child and Family Services (OCFS) programs.

(1) Both, the MACWIS and OCFS personnel use client information to determine if individuals are eligible for federal IV-E Foster Care, IV-E Adoption Assistance or other State funded OCFS programs. Client data is entered directly into MACWIS by OCFS caseworkers, and other DHHS personnel, but is also the result of many internal and external exchanges of system information. If the OCFS eligibility specialist comes up with a result different than MACWIS, relevant information is reviewed for accuracy to determine which assessment was correct. Any required changes are made accordingly. (2) Data pertaining to client eligibility status is sent to **WELFRE** for recipient aid category (RAC) code assignment.

## IT PROCESS: WELFRE Receipt and Disbursement of Client Eligibility Data to Payment Systems.

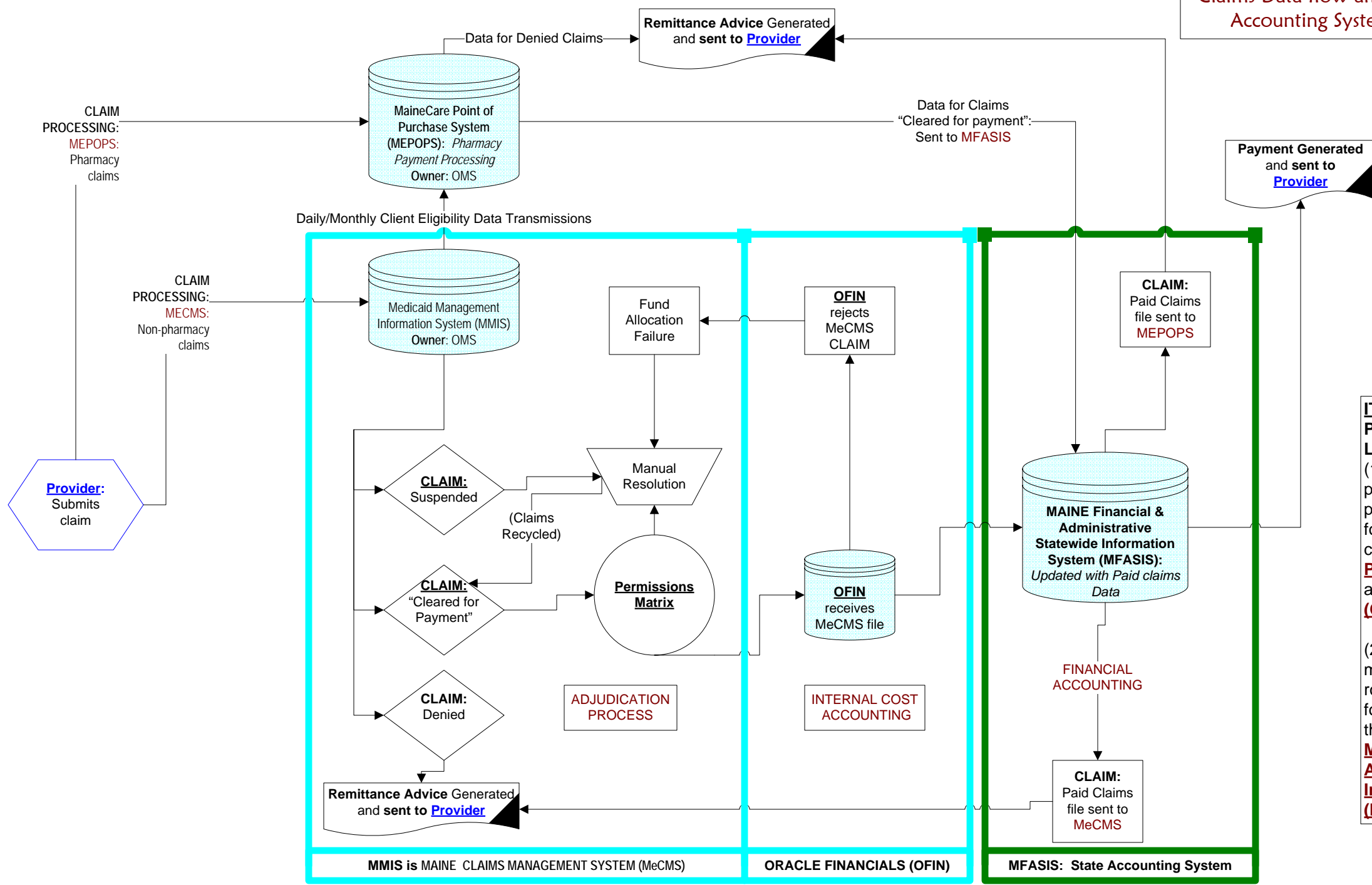
WELFRE assigns RAC codes to each individual case using Bull Interface programming. Payment systems use these RAC codes to assign federal and State funding sources to claims during the adjudication process shown on P-IS-1.2. This information is forwarded to MFASIS for the payment of claims.

### LEGEND

- ➡ = communication or interface of client eligibility data from the **Eligibility Systems**
- ➡ = communication or interface of client eligibility data to the **Payment Systems**
- ➡ = information used for **client eligibility determination / case management** process
- ➡ = **OMS managed** client data information used for **claims adjudication / payment**

# PAYMENT DATA FLOW

Claims Data flow among the Payment and Accounting Systems, October 2006



**IT PROCESS: CLAIMS LIFECYCLE:**

(1) Claims cleared for payment move on to have proper accounting applied for expenditure record classification through the **Permissions Matrix** and **ORACLE Financials (OFIN)**.

(2) Claims that successfully make it through **OFIN** are rolled into one transaction for each provider/vendor that is passed on to the **Maine Financial & Administrative Statewide Information System (MFASIS)**.

## STATE CHILDREN'S INSURANCE PROGRAM

(1)

**Finding Title:** Estimated expenditures reported

**Prior Year Finding:** No

**CFDA:** 93.767

**CFDA Title:** State Children's Health Insurance Program (SCHIP)

**Federal Award:** 05-0405ME5021

**Federal Agency:** U.S. Department of Health & Human Services

**State Department:** Department of Administrative and Financial Services (DAFS)

**Bureau:** Health and Human Services Service Center (H&HSSC)

**Finding Type:** Internal control and compliance

**Compliance Area:** Reporting

**Known Questioned Cost:** None

**Likely Questioned Cost:** None

**Criteria:**

- Attachment A, Subpart C (Basic Guidelines) of OMB Circular A-87, *Cost Principles for State, Local and Indian Tribal Governments*
- 42 CFR §457.630(4)(e)(1) and (2)

**Condition:** The Department of Administrative and Financial Services' Health and Human Services Service Center (H&HSSC) reported \$1.1 million in "estimated" administrative costs as "actual" expenditures on the program's quarterly expenditure reports for the period 7/1/05 through 6/30/06. H&HSSC representatives signed the reports, which require them to certify to the best of their knowledge and belief that "expenditures included in the report are based on the State's accounting of actual recorded expenditures, and are not based on estimates."

**Context:** H&HSSC placed reliance on a consultants' study, which identified additional potentially allocable "budgeted" costs. The Program has a 10% cap on administrative costs; H&HSSC subtracted administrative costs actually incurred from the cap amount available and then added estimated costs equivalent to the remaining cap amount.

**Cause:** H&HSSC did not determine what actual costs were incurred in the areas identified by the consultant but assumed costs to have been incurred.

**Effect:** H&HSSC claimed federal reimbursement in excess of the charges that it could support; however, a questioned cost was not developed as H&HSSC was subsequently able to identify more than \$1.1 million in allowable administrative costs that could be claimed in lieu of the reported "estimated" amounts. Section 3.1 of the SCHIP State plan

## STATE CHILDREN'S INSURANCE PROGRAM

allows Maine to claim health services initiatives' (HIS) costs under the State's 10 percent administrative cap.

**Recommendation:** We recommend that the Health and Human Services Service Center only claim "actual" expenditures on the programs' quarterly expenditure report.

**Management Response/Corrective Action Plan:** *The Department of Administrative and Financial Services, Health and Human Services Service Center agrees with this finding.*

*Beginning July 2007, actual expenditures will be recorded on the program's quarterly reports instead of the consultant's spreadsheet. Also, this step will be added to the procedures documentation for the CMS 21 report.*

**Contact person:** *Chuck Bryant, DAFS, DHHS Service Center - Financial Analyst, 287-3171*

## MEDICAID CLUSTER

(2)

**Finding Title:** Program integrity reviews show over billing of waiver costs

**Prior Year Finding:** No

**CFDA:** 93.775, 93.777, 93.778

**CFDA Title:** Medicaid Cluster

**Federal Award:** 05-0505ME5028, 05-0605ME5028

**Federal Agency:** U.S. Department of Health and Human Services

**State Department:** Health and Human Services (DHHS)

**Bureau:** Adults with Cognitive & Physical Disability Services

**Finding Type:** Internal control and compliance

**Compliance Area:** Allowable costs

**Known Questioned Cost:** \$130,912 (\$206,485 x .634 blended federal financial participation rate)

**Likely Questioned Cost:** Undeterminable

**Criteria:** MaineCare Benefit Manual (Chapter I and Chapter II, §21)

**Condition:** Home and Community Based Services Waiver (Waiver) providers do not have sufficient records to support MaineCare invoices. To date, the DHHS Program Integrity Unit (PIU) has reviewed four providers, each was issued a recoupment letter.

Waiver client reimbursement rates are based on provider budgeted costs. PIU cited the agencies for the following:

- Not incurring or overstating budgeted costs, including having fewer staff than budgeted
- Billing unallowable costs, including personal expenses
- Lacking documentation to support services billed
- Billing for more units of service than actually provided

**Context:** The PIU examined four providers during fiscal year 2006 and recommended significant recoupments for each of these providers. One of the four has agreed to repay \$206,485 for one client. The other three providers, who were requested to repay from \$56,518 to \$539,310 for one or more clients, are in various stages of the appeal process.

According to one national organization, Maine's average Waiver cost of approximately \$79,000 is about twice the national average. During fiscal year 2006, the Medicaid Home and Community Based Services Waiver Program expended \$242 million.

**Cause:** Financial monitoring has been insufficient. The program has not compared providers' actual costs to their estimated costs, nor controlled costs by adjusting rates accordingly.

## MEDICAID CLUSTER

**Effect:** Medicaid costs are higher than necessary. Providers receive payment based on their estimated costs; if estimated costs are not incurred or are overestimated, the providers receive excessive payments.

**Recommendation:** We recommend that the Department establish financial accountability over Waiver expenditures by basing its payments on actual costs. We also recommend that the Department provide the Program Integrity Unit sufficient resources to expand their examination capabilities. We note that the Department is moving from negotiated rates to a published rate payment structure.

**Management Response/Corrective Action Plan:** *The Department of Health and Human Services agrees with the rate recommendation in this finding.*

*The Department is moving toward a published rate system. The rates have been developed through an extensive analysis of cost data and have used this data to set reasonable rates. It is anticipated that these rates will be effective in the second quarter of fiscal year 2008.*

**Contact:** Jane Gallivan, DHHS - Program Systems Director, 287-4212

(3)

**Finding Title:** Insufficient claims payment controls

**Prior Year Finding:** No

**CFDA:** 93.775, 93.777, 93.778

**CFDA Title:** Medicaid Cluster

**Federal Award:** 05-0505ME5028, 05-0605ME5028

**Federal Agency:** U.S. Department of Health and Human Services

**State Department:** Health and Human Services (DHHS)

**Bureau:** Adults with Cognitive & Physical Disability Services

**Finding Type:** Internal control and compliance

**Compliance Area:** Activities allowed or unallowed

**Known Questioned Cost:** \$12,173 (\$19,200 x .634 blended federal financial participation rate)

**Likely Questioned Cost:** Undeterminable

**Criteria:**

- 42 CFR §433.10- §433.131 – Medicaid claims management system requirements
- U.S. Department of Health & Human Services Understanding Medicaid Home and Community Services: A Primer.

**Condition:** The Medicaid Claims Management System (MECMS) has insufficient edit and limit checks to control Waiver expenditures and to provide assurance that only authorized payments



## MEDICAID CLUSTER

are made. MECMS and the Enterprise Information System (EIS) are not fully integrated and do not allow administrators to easily manage or monitor program activity.

MECMS will not prevent providers from front-loading or billing early. A test of payments made for six clients showed that one provider's weekly invoices for two clients were for more units of service than the authorized average. We requested a MECMS query of all similar payments for those clients, for that service code, to that provider. The query showed that the provider billed the system's weekly maximum number of hours until reaching the entire amount authorized for the year. The provider stopped billing by March, when the units of service reached the clients' annual authorized service limit, although service continued through June. Although the provider did not bill more than the total authorized, the claims payment system would not have prevented it. We obtained client service documentation showing that all services billed were provided, although the number of service units was much higher than that on which the rate was established.

MECMS will not prevent over billing. We further tested this internal control weakness by judgmentally selecting two other clients of other providers for whom payment rates had been set based on fewer units of service than the system limit. We requested queries of all payments for that service code, for those clients, to those providers. Our testing was limited as the queries, although straightforward, are time-consuming. They require manual processing through multiple screens; the requested query took experienced Department staff approximately two days. One of the two providers overcharged the program. The provider billed the maximum number of units of service that the system will process; thereby charging \$19,200 more than authorized, and more than the provider's estimated costs. We note that the client was initially authorized 350 days annually at a rate of \$241.83. Halfway through the year the annual days authorized were reduced to 305 days and the rate increased to \$444.17 per day. The provider actually billed for 363 days, at the billing rates in effect at the time.

**Context:** The Waiver program has set its rates to cover provider estimated costs: the rate per unit of service is dependent on how many units are authorized over any given period. If fewer units are authorized the rate per unit is higher; if more units are authorized, the rate is lower. Although the provider's annual cost is to some extent driven by the services that clients require, the providers' estimated costs are allocated to whatever the number of units is. The number of units and the rate per unit are somewhat arbitrary and function primarily as a billing mechanism. Most clients receive services year round even though the number of units authorized is often less than that.

**Cause:** Once payment rates have been established, MECMS generally processes claims without human intervention. For Waiver code W125, Personal Support Services, the only system limit is the weekly maximum number of units that will be paid (168 hours = 7 days X 24 hours). It has no edit or limit checks to ensure that providers do not bill for more than the total dollars or units authorized on a weekly, monthly or annual basis.

Current information systems do not facilitate program management and oversight. MECMS was placed in operation in January 2005; it has limited reporting capacity. The associated Maine Medicaid Decision Support Services database, which summarizes information for reporting, has

## MEDICAID CLUSTER

not worked. Program personnel also use EIS to manage and administer the Home and Community Based Services Waiver program. Although much program information, including units of service and individual client payment rates, is entered into EIS, actual claims payment information does not flow back from MECMS to EIS, but must be obtained by other means.

**Effect:** The rate structure may result in:

- Approved total annual payments being made sooner than authorized
- Units of service provided may not be billed
- Service units may be billed for more than the annual amount authorized

The intent is that the program cover the providers' estimated annual costs but when units are set artificially low, providers may overcharge. We question the federal portion of the excess amount billed (18%), \$12,000. It was not possible to project likely questioned costs because of the number of variables involved.

**Recommendation:** We recommend that the program:

- Authorize annual/weekly units of service that correspond to those actually required.
- Periodically monitor providers to prevent overbilling and unauthorized early billing.
- Incorporate edit or limit checks to restrict payments to total annual units or dollars authorized.
- Include actual payment data in EIS to facilitate program management.
- Recover any overpayments.

**Management Response/Corrective Action Plan:** *The Department agrees with the recommendations.*

- 1. The Department's new Published rate system has specific authorizations based on the member's need.*
- 2. Currently, DHHS and OIT are planning to develop a set of computer programs that will capture over-billing information after the fact and allow for recovery. The timeframe for beginning the development of these programs is targeted for spring 2008, based upon current priorities.*
- 3. DHHS and OIT will review edits and limit checks and its ability to restrict total annual dollars authorized. If this is not easily fixable within MECMS, then this issue will be addressed during the implementation of the Fiscal Agent.*
- 4. DHHS and OIT are also planning to develop a set of computer programs, as part of EIS, that will match claim information to data within EIS; allowing for better program management. The timeframe for beginning the development of these programs is targeted for summer 2008, based upon current priorities.*
- 5. The Division of Program Integrity is currently involved with recovering overpayments as they obtain this information.*

**Contact:** *Jim Lopatosky, DAFS/OIT/DHHS – Information Technology Director, 287-1921*

## MEDICAID CLUSTER

(4)

**Finding Title:** Inadequate financial accountability—payment rates not supported and include unallowable costs

**Prior Year Finding:** 05-57

**CFDA:** 93.775, 93.777, 93.778

**CFDA Title:** Medicaid Cluster

**Federal Award:** 05-0505ME5028, 05-605ME5028

**Federal Agency:** U.S. Department of Health and Human Services

**State Department:** Health and Human Services (DHHS)

**Bureau:** Adults with Cognitive & Physical Disability Services

**Finding Type:** Internal control and compliance

**Compliance Area:** Allowable costs/Cost principles

**Known Questioned Cost:** Undeterminable

**Likely Questioned Cost:** Undeterminable

**Criteria:**

42 CFR §441.302 (b) *Financial accountability*

U.S. Department of Health & Human Services, Understanding Medicaid Home and Community Services: A Primer

42 CFR §441.310 Limits on Federal Financial Participation (FFP)

MaineCare Benefits Manual §21.05-1

**Conditions:** The Home and Community Based Services Waiver Program (Program) does not have adequate internal controls to ensure financial accountability for program expenditures. The Program established payment rates that were not supported, varied widely, were changed to cover provider costs, and included unallowable costs. In our sample of 60, we noted the following:

Unsupported rates:

The Program did not have provider budgets to support rates established for ten of 24 (42%) of Residential Training clients sampled and eight of 29 (28%) of Personal Support Services clients.

Rates are not uniform and change:

The Program can pay markedly different rates for the same client, depending on who their provider is, what the provider includes for estimated costs, and whether that provider has other client vacancies. If the numbers of clients serviced by a provider change, program personnel adjust rates paid for one or more of the remaining clients.

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### Unallowable Administrative Occupancy Costs:

Thirteen of 14 (93%) of the Residential Training budgets received and 15 of the 21 (71%) Personal Support Services budgets included unallowable costs for administrative occupancy.

### Unallowable Start-Up Costs:

One of the 21 (4.8%) Personal Support Services provider budgets included unallowable costs for furnishings and equipment/capital. This provider operates multiple facilities, all of which can be expected to have similar, unallowable costs.

### Unallowable Transportation Costs:

For eleven of 21 (52%) budgets for personal care services (personal support services) for clients, the program set payment rates based on provider budgets that included transportation costs, which are unallowable for personal support services clients.

**Context:** We examined three Waiver categories of service, which together account for approximately 90% of Program expenditures. Budgeted expenditures for these service categories were approximately \$237 million.

### **Cause:**

- The Program never obtained or compared actual provider costs to budgeted provider costs or adjusted its rates accordingly.
- The Program established payment rates for large providers by using a “negotiated rate method” based on specific providers’ expected service costs supported by annual budgets.
- There is no documentation to support rates for smaller providers. The Program rates were based on “whatever was acceptable to the provider” and stayed the same until the provider requested a change.
- Individual regional resource coordinators who approved the rates do not have accounting or finance backgrounds.
- There was limited central oversight of the coordinators that approved rates.
- The Program’s interpretation of allowable costs included unallowable costs such as administrative occupancy costs.
- Unallowable room and board costs are included in approved rates.

**Effect:** State and federal funds have been expended for services that, to some unknown extent, were not allowable. The Program could not support its determination of rates that resulted in budgeted expenditures of \$39.9 and \$32.8 million.

Known questioned costs were not determinable since provider costs are based on provider estimated costs rather than actual costs. Likely questioned costs cannot be projected since known questioned costs are not determinable.

**Recommendation:** We recommend that the Program establish consistent, equitable rates that are based on only allowable, actual costs.

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DHHS indicated that it intends to remove these unallowable costs for rates implemented in January, 2007. The Program is moving to a published rate system that should provide more consistent and equitable treatment of all providers and clients.

**Management Response/Corrective Action Plan:** *The Department of Health and Human Services agrees with this finding.*

*The Department is moving to a standardized rate system, whereby providers receive the same rate for the same service. Additionally, the Department has removed all room and board costs from the standardized rates and will pay for those costs with State general funds appropriated from the legislature for this purpose.*

**Contact:** *Jane Gallivan, DHHS – Central Office - Program Systems Director, 287-4212*

(5)

**Finding Title:** Unallowable targeted case management charges to Medicaid

**Prior Year Finding:** 05-55

**CFDA:** 93.775, 93.777, 93.778

**CFDA Title:** Medicaid Cluster

**Federal Award:** 05-0505ME5028, 05-0605ME5028

**Federal Agency:** U.S. Department of Health and Human Services

**State Department:** Department of Administrative and Financial Services (DAFS); Department of Health and Human Services (DHHS)

**Bureau:** Office of Child and Family Services (OCFS)

Health and Human Services Service Center

**Finding Type:** Internal control and compliance

**Compliance Area:** Allowable costs/Cost principles

**Known Questioned Cost:** \$27,870 (31 unallowable claims at \$899.02 each)

**Likely Questioned Cost:** \$10.6 million (\$20.3 million multiplied by a 52% error rate, or 31 unallowable claims of 60 tested)

**Criteria:**

OMB Circular A-87; 42 USC §1396n(g)(2)

Medicaid State Plan

**Condition:** DHHS does not have adequate procedures in place to identify allowable targeted case management services to foster care clients.

- DHHS has not provided cost information to support rates charged for targeted case management services provided directly by DHHS. Therefore, it is not possible to determine the appropriateness of those federal charges, which for fiscal year 2006 were

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approximately \$35 million. DHHS states that the rates have been verbally approved by the federal government. Representatives from the U.S. Department of Health and Human Services, Office of the Inspector General state that it is the methodology for deriving the rates that is approved, not the actual rates.

- The Maine Automated Child Welfare Information System (MACWIS) generates targeted case management claims to Medicaid based on information entered. MACWIS log entries do not distinguish between Medicaid allowable case management and Title IV-E Foster Care and other non-Medicaid reimbursable services.
- Multiple targeted case management claims can be generated by a single home visit if a caseworker copies a client log entry into the records of other children in the household, which could result in duplicate claims being paid for a family with several children.
- Billing policies for case management services are inconsistent. The Office of Elder Services (OES) generates a Medicaid claim for a minimum of one half hour of client services whereas the OCFS generates a claim for only 15 minutes.
- State matching costs for case management are based on calculations, not actual costs.
- OCFS methods used to charge Title IV-E for case management and Medicaid case management are inconsistent and could result in overbilling. Case management services are billed to Title IV-E based on a pro-rata share of caseworker time, whereas Medicaid is charged based on a monthly rate per client.
- OCFS and the OES do not have adequate controls in place to reconcile claims paid with claims submitted to the Office of MaineCare Services (OMS) for reimbursement.

**Context:** In fiscal year 2006, the total State and federal share of targeted case management expenditures was approximately \$93 million. Of this amount, Medicaid paid DHHS approximately \$50 million with the remainder paid to other providers. Of the \$50 million, approximately \$35 million was reimbursed by the federal government.

Of the 60 TCM claims from OCFS that we tested, 31 (52%) of the caseworker files document activities (such as making arrangements for visitation) that constitute normal caseworker services rather than special arrangements for services to clients eligible for the Title IV-E programs. We also note that the U.S. Department of Health and Human Services, Office of Inspector General has audited targeted case management; its final report has not yet been released.

**Cause:** DHHS has not given adequate consideration to the guidance provided by the Centers for Medicare and Medicaid Services (CMS); and has not sufficiently defined or made a distinction between targeted case management services and direct Title IV-E case management services.

**Effect:** Medicaid funds may be expended for unallowable costs resulting in current and future questioned costs. If DHHS did not incur matching costs it will result in questioned costs.

**Recommendation:** We recommend that the Department:

- Work with CMS to resolve all issues to the satisfaction of CMS with respect to billing for case management services and adequately document all policies and procedures
- Establish consistent policies and procedures in regards to billing for case management between State agencies

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- Ensure that computer systems involved in tracking case management have the necessary controls in place to adequately distinguish chargeable TCM from case management not billable to Medicaid
- Document its expenditures of State funds to match the federal participation

**Management Response/Corrective Action Plan:** *The Department of Health and Human Services disagrees with the questioned costs.*

*The Office of Child and Family Services performs case management services. It is considered targeted because it is provided to a target population, not because it is something other than “direct case management”. The Health Care Financing Administration (HCFA) agreed to our current TCM rate in 1996. Representatives of Maine’s DHHS met with officials of HCFA in Boston on or about 2/29/96 to discuss Medicaid reimbursement for TCM services. As a result of the discussion, the Department and HCFA agreed upon a Medicaid reimbursement rate for TCM services. The Department subsequently submitted bills to HCFA for TCM services as agreed upon and HCFA issued payment to DHS/DHHS in accordance with the terms of the 1996 agreement. Having said that, effective July 2006, DHHS has developed a new rate methodology as detailed in the OCFS cost allocation plan, whereby a Random Moment Time Study (RMTS) is used to determine what percentage of allowable costs is billed to Title IV-E. The remainder is built into the TCM rate that can be charged to Medicaid. The calculation will be total expenditures related to caseworkers and their work, including office and supervision overhead, multiplied by the percentage defined by the time study. The calculation will be done quarterly, giving the department a monthly billable rate. It should be noted that the RMTS only establishes the TCM rate; it is not used for billing purposes for individual claims. Billing for TCM is done on an individual monthly basis that is case specific for Medicaid eligible clients only. The evidence to support individual monthly TCM claims is documented in the MACWIS narrative log.*

*During fiscal year 2008, the TCM rate was reduced from \$899 to \$735.83.*

*Because the definition was admittedly ambiguous, Congress recently amended the definition of an appropriate Targeted Case Management Service claimable under Medicaid in Section 6052 of the Deficit Reduction Act of 2005 (DRA) – Reforms of Case Management and Targeted Case Management. As a result, effective January 2006, Maine no longer bills Medicaid for TCM services to children who are Title IV-E eligible.*

**Contact:** *Kirsten Figueroa, DHHS - Deputy Commissioner of Finance, 287-1921*

**Auditor’s Conclusion:** We disagree with management’s response for the following reasons:

We concur, as DHHS states, that the rate that it is currently charging for targeted case management dates back to 1996. However, we believe that DHHS has not adequately considered later federal guidance. The Centers for Medicare & Medicaid Services (CMS) issued a State Medicaid Director Letter (SMDL#01-013) dated January 19, 2001. The letter urges states to “undertake a careful review to ensure the activities to be claimed under Medicaid meet the

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definition of case management and are not directly connected to the delivery of foster care benefits and services.”

The finding remains as stated.

(6)

**Finding Title:** Noncompliance and inadequate internal control over Medicare Part B eligibility

**Prior Year Finding:** No

**CFDA:** 93.775, 93.777, 93.778

**CFDA Title:** Medicaid Cluster

**Federal Award:** 05-0505ME5028, 05-0605ME5028

**Federal Agency:** U.S. Department of Health and Human Services

**State Department:** Health and Human Services (DHHS)

**Bureau:** Office of Integrated Access and Support

Office of MaineCare Services

Financial Management Services

**Finding Type:** Internal control and compliance

**Compliance Area:** Eligibility

**Known Questioned Cost:** \$112

This is the federal portion of two Medicare Part B insurance premiums paid by the State for Medicaid ineligible persons. (two individuals at \$88.50 each at a federal participation rate of 63.4%)

**Likely Questioned Cost:** \$1,186,020

This was computed by applying the sample error rate of 3.33% to the population of federal expenditures for Medicare Part B insurance (\$35,616,230).

**Criteria:**

- 42 CFR §431.625
- MaineCare Eligibility Manual, Chapter 332, Appendix (3-1)

**Condition:** DHHS charged the Medicaid program for Medicare Part B premiums for individuals who were not eligible or who were identified as ineligible. Of the 60 individuals included in our test, DHHS automated eligibility systems showed that five were not eligible. However, once individual case histories for the five were researched, only two of the five, or 3.33% of the 60 sampled were not eligible.

**Context:** In fiscal year 2006 DHHS paid \$56.1 million to the Centers for Medicare and Medicaid Services for Medicare Part B coverage.



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**Cause:** DHHS made the monthly payments without comparing the identities of the insured to the State's Medicaid eligibility records. For the three individuals who the system showed ineligible in error, two incorrect assessments were due to problems with data exchange between internal eligibility systems and one to case worker error.

**Effect:** Medicaid costs are higher than necessary. DHHS has paid premiums for ineligible individuals. Projections of the results of our sample indicate that as much as \$.7 million from the General Fund and \$1.2 million of federal funds could have been saved in fiscal year 2006.

**Recommendation:** We recommend that the Department develop electronic matching procedures to ensure that payments are made only for eligible individuals.

**Management Response/Corrective Action Plan:** *The Department of Health and Human Services agrees with the finding.*

*The Department agrees that we do need to perform regular reconciliations of what CMS bills the State of Maine for Buy-In recipients in order to verify accuracy in the payment process. The reconciliation will identify those individuals eligible for payment and those that are not. The Department plans to have the reconciliation in place by December 2007 and will perform the reconciliation every 6 months in order to maintain payment accuracy.*

**Contact:** Tom Keyes, DHHS – Office of Integrated Access and Support (OIAS), Deputy Director, 287-2310

(7)

**Finding Title:** Controls insufficient to prevent unallowable waiver transportation costs

**Prior Year Finding:** No

**CFDA:** 93.775, 93.777, 93.778

**CFDA Title:** Medicaid Cluster

**Federal Award:** 05-0505ME5028, 05-0605ME5028

**Federal Agency:** U.S. Department of Health and Human Services

**State Department:** Health and Human Services (DHHS)

**Bureau:** Adults with Cognitive & Physical Disability Services

**Finding Type:** Internal control and compliance

**Compliance Area:** Activities allowed or unallowed

**Known Questioned Cost:** Undeterminable

**Likely Questioned Cost:** Undeterminable

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### Criteria:

- Application for a § 1915 (c) Home and Community-Based Waiver [version 3.3] – Instructions, Technical Guide and Review Criteria
  - Appendix C, Attachment: Core Service Definitions – B-3. Non-Medical Transportation)
- State Organization and General Administration, Assurance of Transportation (42 CFR §431.53)
- Services: General Provisions, Transportation (42 CFR §440.170(a))

**Condition:** The Department of Health and Human Services does not ensure that the Waiver program does not pay for medical transportation services that are required to be provided by the Medicaid State Plan. According to federal technical guidance, non-medical transportation services are allowed under the Waiver program. However, medical transportation services required by the general Medicaid requirements (provided under the State Plan) shall not be charged to the Waiver program. We found instances where client Individual Care Plans indicated that all transportation needs, including to medical appointments, were provided by the Waiver provider.

**Context:** Twenty of the sixty Individual Care Plans examined stated that all transportation needs, including to medical appointments, were provided by the Waiver provider. Payment rates for waiver services generally have been based on budgets that included funding for transportation. In many cases, providers' budgets include purchase of vehicles. We do not question costs as transportation costs are built into provider rates and some transportation costs are allowable Waiver charges.

**Cause:** Program personnel indicated that they have guidelines to limit the transportation costs that providers can build into their facility budgets but there is no apparent control in place to limit vehicle use to non-medical transportation. As vehicles are available, they appear to be used to meet all client needs including medical transportation.

**Effect:** The Waiver program is not compliant with the federal requirements regarding transportation charges.

**Recommendation:** We recommend that the Department advise providers that medical transportation must be billed separately and that it structure rates so that those costs are not paid with Waiver funds.

**Management Response/Corrective Action Plan:** *The Department of Health and Human Services agrees with the finding. The Department will continue to inform Providers to bill State Plan services for medical transportation.*

*The new published rates include transportation to non-medical services only. It must be recognized that there is limited availability of on-demand transportation services. The waiver program provides services on a 24/7 basis. In virtually all areas of the State, capacity to provide State plan transportation service does not exist. The priority of waiver services is to always provide for the health, welfare and safety of the program's participants which necessitates*

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*availability of transportation services on very short notice. The Department will develop a process to document the refusal, denial or unavailability of State plan transportation services for medical transportation in order to monitor the waiver program.*

**Contact:** Jane Gallivan, DHHS - Program Systems Director, 287-4212

(8)

**Finding Title:** Unallowable vocational and social services

**Prior Year Finding:** No

**CFDA:** 93.775, 93.777, 93.778

**CFDA Title:** Medicaid Cluster

**Federal Award:** 05-0505ME5028, 05-0605ME5028

**Federal Agency:** U.S. Department of Health and Human Services

**State Department:** Health and Human Services (DHHS)

**Bureau:** Adults with Cognitive & Physical Disability Services

**Finding Type:** Internal control and compliance

**Compliance Area:** Activities allowed or unallowed

**Known Questioned Cost:** Undeterminable

**Likely Questioned Cost:** Undeterminable

**Criteria:**

- MaineCare Benefits Manual, Home and Community Benefits for Members with Mental Retardation, Non-covered Services (§21.07)
- Application for a §1915 (c) Home and Community-Based Waiver [version 3.3] – Instructions, Technical Guide and Review Criteria
  - Appendix C, Attachment: Core Service Definition – 8. Day Habilitation
  - Appendix C-3: Waiver Services Specifications – G. Prevocational and Supported Employment Services

**Condition:** The Department of Health and Human Services has included unallowable vocational, recreational and social services in clients' Individual Care Plans (ICPs). According to federal technical guidance, waiver funding is not available for the provision of vocational services (e.g. sheltered work performed in a facility) where individuals are supervised in producing goods or performing services under contract to third parties. Additionally, waiver payments for day habilitation may not provide for services that are vocational in nature (e.g. sheltered work). The MaineCare Benefits Manual prohibits reimbursement of services provided to members of which the basic nature is to provide vocational, social, academic or recreational services.

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**Context:** In our sample of 60 waiver client's ICPs, we found ten clients whose ICPs indicated unallowable sheltered work, employment by the day habilitation provider, or apparent social and recreational services. Examples of such unallowable services included the following:

- One ICP identified the service authorized as Supported Employment rather than as it was budgeted as Day Habilitation. The worksite is a Certified Work Center where individuals are supervised in producing goods or performing services under contract to third parties. Such Work Centers constitute sheltered employment; the activity is neither Supported Employment, which is in a regular work setting, nor Day Habilitation; it is not an allowable use of Waiver funds. Budgeted annualized costs for this service were \$12,977; the federal share would be \$8,100.
- A second ICP stated, "Some paid work as part of Day Services..." The client's budgeted annualized Day Habilitation costs were \$16,926.
- A third ICP included a description of activities that appeared to be predominately social and recreational services.
- Some Waiver clients earn some money by "working" for the providers who provide them Day Habilitation services. It is not always clear that the funding for this work is from other than Day Habilitation funds. Likewise, care plan narratives sometimes lack clarity as to the basic nature and medical necessity of all activities in which clients are engaged.

**Cause:** Narrative descriptions are not specific as to the exact nature of activities engaged in, the allowability of the activity for Medicaid funding or, if the activity is not funded by Medicaid, how it is funded. Unintentional miscoding of activities may also have occurred.

**Effect:** Some services made available to Waiver clients may not have been allowable Waiver charges or may have been miscoded. There is a potential for unallowable costs and any miscoding distorts program reporting.

**Recommendation:** We recommend that the Department personnel clearly describe the medical necessity of services provided, document any other funding sources for payments or services made to, or on behalf of, Waiver clients, and take due care to properly code the use of Waiver funds.

**Management Response/Corrective Action Plan:** *The Department of Health and Human Services partially agrees with this finding and offers the following as responses to the cited examples.*

*Regarding sample number one the Department agrees, and the consumer authorization has since been changed to reflect the accurate delivery of the service category.*

*With sample number two it is acknowledged that very limited remuneration occurred. This is not uncommon at a habilitation service site. Preparation for future employment is seen as habilitative and service plans often call for minor payment for contracted type work. In instances such as this the scope of work is limited and the day's events are primarily devoted to habilitative exercise that are not reimbursed. Often the total week's payment is \$5.00 or less; it*

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*is, however, the earning of this payment that greatly enhances the learning experience and develops pride in the events.*

*Sample number three cites opportunities provided to the consumer that on paper appear to be recreational in nature. The detail of what occurs during a community outing is not described, but attending church or the local gym are mechanisms to skill building, such as knowing how to use unknown public facilities appropriately (locker, shower); health benefits from the exercise, social and spiritual health from attending and participating in a community activity. CMS interprets “an activity that may appear to be a recreational activity may be rehabilitative if it is furnished with a focus on medical or remedial outcomes to address a particular impairment of functional loss”.*

*The Department cites these as examples of community inclusion exercise and opportunities that are invaluable to ones integration into the community, one of the highest goals and outcomes that the waiver support can offer.*

**Contact:** Jane Gallivan, DHHS - Program Systems Director, 287-4212

**Auditor’s Conclusion:** For the third sample, while we recognize that these activities may present a beneficial opportunity to the Waiver participant, Medicaid regulations state that the basic nature of a reimbursable activity cannot be social or recreational.

The finding remains as stated.

(9)

**Finding Title:** Prescription co-payment not charged and amounts overpaid for prescription drugs

**Prior Year Finding:** No

**CFDA:** 93.775, 93.777, 93.778

**CFDA Title:** Medicaid Cluster

**Federal Award:** 05-0505ME5028, 05-0605ME5028

**Federal Agency:** U.S. Department of Health and Human Services

**State Department:** Health and Human Services (DHHS)

**Bureau:** Office of MaineCare Services

**Finding Type:** Internal control and compliance

**Compliance Area:** Activities allowed or unallowed, Allowable costs/Cost principles

**Known Questioned Cost:**  $\$1.60 + \$6.40 = \$8$

This is the federal portion (\$1.60) of a co-payment that was not charged and the federal portion of two overpayments (\$6.40) as referred to in the Condition section of this finding.

**Likely Questioned Cost:**  $\$47,089 + \$204,052 = \$251,141$

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The likely questioned cost amounts associated with co-payments and overpayments were computed by applying the respective error rates of .03% and .13% to the population of federal expenditures for prescription drugs (\$156,963,014).

**Criteria:** MaineCare Benefits Manual, Chapter II §80

**Condition:** Three of 40 pharmacy transactions examined were paid incorrectly. In one instance the Department did not charge a member a standard MaineCare co-payment of \$2.50; the transaction was not exempt according to the provisions of the MaineCare Benefits Manual, Chapter II §80. In two other instances, the Department paid the pharmacy more than the federal upper limit. Payments were made for \$8.49 and \$15.24 rather than \$5.85 and \$7.85.

**Context:** The Medicaid program expended approximately \$247.5 million for prescription drugs in fiscal year 2006.

**Cause:** The payment errors were caused by errors in information contained in two electronic interface systems. With regard to the co-payment error, the prescription claims processing software received an electronic interface from the State's WELFRE system that incorrectly indicated that the member should not be charged a co-payment. The interface allowed an exemption for all members classified within a certain recipient aid category (1M). This is not consistent with State policy. With regard to the upper limit errors, the State's pharmacy claims processor relied on an electronic interface of data from an independent industry provider of drug information that contained incorrect information.

**Effect:** Pharmacy costs were shifted from the member to the federal and State governments and costs were overpaid.

**Recommendation:** We recommend that the Department review and correct the electronic rules governing member co-payments. We recommend that the Department compare the federal upper limit amounts in the claims processing database to the federal upper limit amounts issued by the Centers for Medicaid and Medicare Services; and make any necessary corrections. In addition, we also recommend that internal control procedures be established to ensure these amounts are correct on an ongoing basis.

**Management Response/Corrective Action Plan:** *The Department of Health and Human Services agrees with this finding.*

*The Office of Integrated Services and the Office of MaineCare Services are reviewing the interface co-pay rules. The results of the review will be integrated into the interface to provide consistency with DHHS policies. The interface is targeted for completion in March 2008.*

*The Department of Health and Human Services concurs with the recommendation of reviewing/comparing the federal upper limit amounts in the claims processing database to the federal upper limit amounts issued by the Centers for Medicaid and Medicare Services. DHHS will require a quarterly review of CMS – To Medispan – To GHS - federal upper limit amounts and make corrections of any discrepancies and will establish a procedure for random auditing of*

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*the State FULs to the current CMS/ Medispan tape to monitor quarterly review effectiveness (anticipated implementation date: October 2007).*

**Contact:** Carol Bean, DHHS - Comprehensive Health Planner II, 287-3941

(10)

**Finding Title:** Information technology contracts insufficient and IT policies and controls inadequate

**Prior Year Finding:** No

**CFDA:** 93.775, 93.777, 93.778

**CFDA Title:** Medicaid Cluster

**Federal Award:** 05-0505ME5028, 05-0605ME5028  
05-0505ME5048, 05-0605ME5048

**Federal Agency:** U.S. Department of Health and Human Services

**State Department:** Administrative and Financial Services (DAFS)

**Bureau:** Office of Information Technology (OIT)  
Systems for Office of MaineCare Services (OMS)  
Office of Integrated Access & Support (OIAS)

**Finding Type:** Internal control and compliance

**Compliance Area:** Special tests and provisions

**Known Questioned Cost:** None

**Likely Questioned Cost:** None

### Criteria:

- 45 CFR §95.617(a) - Software and ownership rights
- The State information security policy adopted by the Information Services Policy Board (5 MSRA §1871 – §1896)
- Health Insurance Portability and Accountability Act of 1996 (HIPAA) - The HIPAA Security and Privacy Rules require all covered entities to protect the electronic protected health information that they use or disclose to business associates, trading partners or other entities.

**Condition:** OIT personnel responsible for computer systems activities of DHHS have not established sufficient procedures to comply with State information security policies, which also results in noncompliance with HIPAA. Departmental IT security policies do not sufficiently address a number of security risks, including the following:

- Third party system access
- Network-to-network connections that allow multiple users or systems from a third party to interact with State resources (Type of access and reasons for access should be driven by a business need, which must be scrutinized by account management in accordance

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with State policy. A complete record of access granted and its usage should be documented for monitoring purposes.)

- Personnel screenings of prospective IT contractors who will be granted access to State Information Systems
- User training to provide security awareness, and updates to security policies or procedures (A failure to adequately perform these activities would affect the reporting of incidents and vulnerabilities as well.)
- Documentation of operating procedures and responsibilities for all information processing

We note that the State contracted with a vendor on June 2, 2005 to develop and formally document all information security policies and procedures.

- Internal controls over information security for MECMS are not operating effectively. DHHS has inappropriately assigned user privileges, including system level access, to vendors and has not adequately monitored them. Also, DHHS did not maintain documentation of system usage that would allow user activity to be reviewed on a regular and independent basis.
- DHHS IT contractual agreements are inadequate to minimize risk to the State in the following areas:
  - State IT management authority over vendor activities performed
  - Competency of the vendor contractors performing the work
  - State ownership of script/coding and supporting documentation of new IT processes as produced
  - Access to script/coding for new IT processes held in escrow during the development phases
  - Monitoring of vendor activity and limiting vendor access to specific timeframes
  - Testing the effectiveness of new program functionality
  - Sufficient access to vendors

**Context:** The State security policy was adopted by the Information Services Policy Board on December 19, 2002 to provide a uniform set of information technology security policies, standards and general guidelines for State government in accordance with 5 MSRA §§ 1871 – 1896. This policy requires that agencies establish and document detailed procedures that provide assurance that prudent steps have been taken to ensure the integrity, confidentiality, and availability of information systems.

**Cause:** Ongoing technical difficulties and frequent system enhancements related to DHHS programs have created pressure to resolve system problems in the shortest time possible.

**Effect:** Insufficient IT policies have resulted in the following:

- Noncompliance with information security guidelines
- Inadequate procedures to address IT vendor failures to meet contractual obligations
- The integrity, confidentiality, and availability of State information may be compromised for all IT systems administered by the Department



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- The Department does not have ownership or documentation of all MECMS technical design plans and payment logic rules

**Recommendation:** We recommend that the Department improve its information security policies and procedures.

**Management Response/Corrective Action Plan:** *Department of Administration and Financial Services, Office of Information Technology partially agrees with this finding.*

*The audit finding suggests that OIT-DHHS does not have formal IT Security Policies or Procedures for its Automated Data Processing systems. OIT-DHHS had contracted with a vendor to interview all IT groups within DHHS and develop an enterprise-wide (DHHS) review of IT Security Policies and Procedures to ensure the Department is consistent with the State IT Security Policy. The deliverables for this project were completed in the fall of 2005. In December 2006, OIT-DHHS contracted with a vendor to review and augment the current Security Policies and Procedure documents to ensure compliance with HIPAA. Input has been received; however, the Department hasn't yet implemented all of the suggestions.*

*In fiscal year 2008, OIT-DHHS will work to develop an approach that ensures a DHHS-wide report on application systems. The report will include the following components for applications:*

- A. Physical security;*
- B. Equipment security;*
- C. Software and data security, including periodic penetration testing;*
- D. Telecommunications security;*
- E. Personnel security; Contingency plans;*
- F. Emergency preparedness; and*
- G. Designation of an Agency ADP Security Manager(s)*

*In order to balance workload, it is envisioned that reviews will happen for half of the applications in one fiscal year, the other half in the second. The feasibility of this report will consider the DHHS IT Security policy, the IRS Safeguard Review, and SSA Review. The approach and plan will be developed by January 31, 2008. The schedule for implementing this plan will be included in the January 31<sup>st</sup> deliverable.*

**Contact:** *Brian Guerrette, DHHS/OIT/DAFS, Systems Section Manager, 287-1748*

**Auditor's Conclusion:** While the Department has recognized the need for compliant policies and procedures, it has not yet implemented all necessary procedures nor documented them. The finding remains as stated.

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(11)

**Finding Title:** Eligibility controls inadequate to ensure that payments are made from the appropriate program for only eligible individuals

**Prior Year Finding:** No

**CFDA:** 93.775, 93.777, 93.778 and 93.767

**CFDA Title:** Medicaid Cluster

State Children's Insurance Program (SCHIP)

**Federal Award:** 05-0505ME5028, 05-0605ME5028

05-0505ME5048, 05-0605ME5048

**Federal Agency:** U.S. Department of Health and Human Services

**State Department:** Department of Administrative and Financial Services (DAFS)

Department of Health and Human Services (DHHS)

**Bureau:** Office of MaineCare Services (OMS)

Office of Integrated Access & Support (OIAS)

Office of Information Technology (OIT)

**Finding Type:** Internal control and compliance

**Compliance Area:** Eligibility

### **Known Questioned Cost:**

Medicaid - \$292

\$292 is the federal charge paid by the State for an ineligible person in a test of \$1,228,158 in non-pharmacy claims, a dollar error rate of 0.0238%.

SCHIP -  $\$3,465 + \$1,354 = \$4,819$

\$3,465 is the federal charge paid by the State for ineligible persons in a test of \$13,398 in non-pharmacy claims, a dollar error rate of 25.86%.

\$1,354 is the federal charge paid by the State for ineligible persons in a test of \$5,024 in pharmacy claims, a dollar error rate of 26.95%.

### **Likely Questioned Cost:**

**Medicaid:** \$306,576

\$306,576 is the likely questioned costs projected by multiplying the total non-pharmacy expenditures of \$2,011,149,043 for fiscal year 2006 by the dollar error rate (approximately .0238%) from the sample at the federal financial participation rate (approximately 64%).

**SCHIP:**  $\$3,978,636 + \$856,562 = \$4,835,198$

\$3,978,636 is the likely questioned costs projected by multiplying the total non-pharmacy expenditures of \$20,296,184 for fiscal year 2006 by the dollar error rate (approximately 25.86%) from the sample at the federal financial participation share (approximately 75.8%).

\$856,562 is the likely questioned costs projected by multiplying the federal pharmacy based Medicaid expenditures of \$3,177,383 for fiscal year 2006 at the dollar error rate (approximately 26.95%) from the sample.

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**Criteria:** OMB Circular A-102 Common Rule

45 CFR §92.20

42 USC §1320b-7(d)

42 CFR §431.10, §435.916, §435.907, §435.913, §435.910, §435.920

**Condition:** DHHS does not have adequate internal controls in place for the Medicaid and SCHIP programs to determine program eligibility, to maintain records of eligibility determinations or to charge the appropriate program for the associated costs of eligible individuals.

We tested eligibility determinations for 180 Medicaid and SCHIP client payments; these consisted of 60 Medicaid and 40 SCHIP non-pharmacy payments and 40 Medicaid and 40 SCHIP pharmacy payments.

- For Medicaid, one (1.7%) of the 60 non-pharmacy clients was not eligible; all of the 40 pharmacy clients were eligible. The ineligible client had no record in the Automated Client Eligibility System (ACES) and had no activity since 1998 in WELFRE (the legacy eligibility system.) As noted below, a high percentage of SCHIP clients tested were later determined to have been Medicaid eligible but charges were not moved to the Medicaid program.
- For SCHIP, two (5%) of the 40 non-pharmacy clients and seven (17.5%) of the 40 pharmacy clients were not eligible. The two non-pharmacy clients were not eligible for the SCHIP program; one was not eligible because other insurance was available, and one had not been eligible since 2004. All seven pharmacy clients had been determined eligible at the time payments were made, but were retroactively determined to be eligible for Medicaid, not SCHIP, as a result of additional information entered later. DHHS did not shift the associated charges between the programs when the eligibility determination changed, resulting in a disparity between program eligibility and program payments. The original eligibility determination was overwritten, and thereby deleted from the legacy eligibility system (WELFRE), with no audit trail.

**Context:** Medicaid is a \$2 billion program, funded 64% with federal financial participation. SCHIP is a \$33 million program, funded 76% with federal financial participation.

For the Medicaid and SCHIP programs, DHHS uses three interconnected computer systems: Automated Client Eligibility System (ACES), Welfare Information System (WELFRE), and Maine Claims Management System (MECMS) to determine client eligibility and assign client claims to the appropriate program for payment. Information flows from ACES to WELFRE to MECMS. It is necessary to look at all three in order to determine whether payments were made on behalf of eligible clients for allowable services by the appropriate program.

OIAS is responsible for determining eligibility. Its eligibility specialists interview clients, maintain case files, and verify income and assets. The eligibility specialists use ACES to record their determination; ACES is a “realtime” system, which also captures information used in determining eligibility by ongoing data exchanges. WELFRE is a legacy system (the predecessor to ACES), which receives eligibility determination codes from ACES and assigns them to recipient aid categories (RAC codes). It then sends the information on to the “rules engine”, which is operated by a contractor, Client Network Services, Inc. (CNSI), as part of MECMS

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within OMS. MECMS has no direct access to ACES but references the RAC codes to process payments. It is in MECMS that the account coding takes place that assigns claims to either Medicaid or SCHIP for payment.

**Cause:** DHHS administers both federal and State funded programs under a single catch-all entity, MaineCare, which results in a lack of clarity regarding individual client eligibility for specific federal or State program benefits. Medicaid, SCHIPS, Dirigo, and non State Supplemental are all treated as MaineCare, with the ACES programming and OIAS policy manuals written accordingly. This conflicts with Departmental obligations to simultaneously administer multiple, distinct federal and State funded programs. The lack of clarity is compounded because, while the OIAS ACES system determines eligibility, the OMS MECMS system determines which program(s) to charge. CNSI controls the program logic governing payments, and because OMS does not have it, OMS could not determine or explain why payments were made for individuals who are not shown as eligible.

DHHS has no policy or procedures to synchronize retroactive changes in client eligibility to payment for those services; no policy or limit regarding how far back to change eligibility status; poor communication between its own offices; ineffective communication with the Department of Administrative and Financial Services - Office of Information Technology; and no control or policy regarding maintaining a permanent audit trail of eligibility determinations in the eligibility systems. However, MECMS downloads from WELFRE and maintains a complete history, which can be researched on an exception basis.

Also, program assignment errors can occur because unique codes are consolidated into one as information moves from ACES to WELFRE. Although none were included in our test sample, certain client eligibility determination codes (MF19, MF31, MFLP, MFSC, MFSP and MFCC) in ACES are summarized into one RAC code (ME) in WELFRE. Individuals in these categories can be eligible for either Medicaid or SCHIP depending on the client's (or client's parents) income and age. Similarly, individuals may be coded eligible as Family Related Adult but be eligible for either Medicaid or the State funded Dirigo program, depending on income. Appropriate assignment to a program requires that income and/or age also be considered, however that information is not transmitted from ACES to WELFRE.

With regard to the existence of other insurance, although the SCHIP client case file noted the existence of other insurance, OIAS did not properly consider it to determine the applicant ineligible, perhaps due to inadequate ACES programming. (Third Party Liability (TPL) information is also obtained by a separate DHHS unit to ensure that Medicaid is the payer of last resort but that TPL information is not incorporated into the ACES system for OIAS use in redetermining eligibility; TPL payments are perceived by OIAS as completely a function of the Office of MaineCare Services.)

**Effect:** Program costs may be charged to the wrong State or federal programs. SCHIP is a much smaller program than Medicaid; it has a higher percentage of federal funding and has only limited funding available. Costs improperly allocated to SCHIP may result in funds not being available to provide services to eligible individuals. Costs may be disallowed for any ineligible client. SCHIP client paid co-pays may have been unwarranted. Medicaid costs are understated to

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the extent that they were incorrectly paid by SCHIP. The SCHIP error rates constitute material noncompliance with federal eligibility requirements.

As for ineligibility due to the existence of other insurance, while the other insurance would not cause an individual to be ineligible for Medicaid, it would cause children applying for SCHIP to be ineligible. Incomplete records result in inconsistent and misleading client eligibility information. The deletion or overwrite of client eligibility history by the Bull interface process (ACES to WELFRE) results in the elimination of an audit trail and is, therefore, a control issue.

**Recommendation:** We recommend that the Department:

- Immediately establish a means to adequately trace activities related to the distinct federal and State funded programs, which are administered as MaineCare.
- More clearly define and consistently support the coordination of specific roles assigned to the different agencies responsible for the administration of all DHHS programs, internal and external to the Department, including system operations carried out by DAFS/OIT.
- Establish a policy regarding retroactive determination of eligibility and align the costs to the affected programs.
- Secure and maintain programming logic for all systems activity.

**Management Response/Corrective Action Plan:** *The Department of Health and Human Services partially agrees with this finding, and offers the following:*

*OIAS disagrees with the statement “With regard to the existence of other insurance, although the SCHIP client case file noted the existence of other insurance, OIAS did not properly consider it to determine the applicant ineligible”. This statement seems to imply that OIAS should find MaineCare Expansion eligible individuals ineligible because they have other health insurance.*

*OIAS does not determine ineligibility for our MaineCare Expansion individuals on the basis of having health insurance. They can be eligible for MaineCare; the issue would be what funding applies, Title XXI or Title XIV. Currently there is no mechanism to ensure that children enrolled in Medicaid expansion bill appropriately to Medicaid (Title XIX) or SCHIP (Title XXI). It should be noted that on average only 10% of this population has insurance coverage other than Medicaid. The Department is currently exploring options to address this issue. Additionally, the Department is transitioning its claims management system to a fiscal agent. As part of that transition, it will be expected that the fiscal agent system, as part of its TPL component, can delineate between those children who do have insurance and those who do not, therefore ensuring appropriate billing to Title XIX or XXI.*

*Specific to the statements regarding the process whereby computer systems (ACES, MACWIS, WELFRE, and MECMS) pass eligibility and RAC Code information between each other, the Department and the Office of Information Technology are reviewing the RAC process as DHHS transitions to a fiscal agent for claims management.*

*There is an effort underway to explore the use and process of Recipient Aid Categories; the intent is to validate the way they are used within the different applications including ACES,*

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*MACWIS, WELFRE and MECMS. During fiscal year 2008, the expected outcomes of this group will be:*

- *A documented understanding of how things work today; this document currently does not exist*
- *A list of known issues and potential solutions/corrections*
- *As necessary, recommendations for possible replacement of this process.*

*A list of issues will be prioritized by the different business areas and added to the specific application work plans. The recommendations will be brought to senior management of DHHS and OIT to determine direction and prioritization of this work.*

**Contact:** *Jim Lopatosky, DAFS/OIT/DHHS – Information Technology Director, 287-1921*

(12)

**Finding Title:** Cost of Care not deducted from payments to nursing home providers

**Prior Year Finding:** No

**CFDA:** 93.775, 93.777, 93.778

**CFDA Title:** Medicaid Cluster

**Federal Award:** 05-0505ME5028, 05-0605ME5028

**Federal Agency:** U.S. Department of Health and Human Services

**State Department:** Health and Human Services (DHHS)

**Bureau:** Office of MaineCare Services (OMS)

**Finding Type:** Internal control and compliance

**Compliance Area:** Allowable costs/Cost principles

**Known Questioned Cost:** \$117

This is the federal portion of an overpayment (3.57% of sample) made by the State to a nursing home provider.

**Likely Questioned Cost:** \$3,575,587

The likely questioned cost amount was computed by applying the sample error rate of 3.57% to the population of federal expenditures for the Aged (\$100,156,499).

**Criteria:**

- MaineCare Benefits Manual, Chapter 1, §1.09
- MaineCare Eligibility Manual §4400
- Cost Principles for State, Local, and Indian Tribal Governments (OMB Circular A-87, Attachment A, paragraph C)

**Condition:** The Maine Claims Management System (MECMS) did not consistently deduct the Cost of Care assessment from payments to nursing homes. Detail testing of a sample of 60 paid claims revealed that a nursing home claim was overpaid because the Cost of Care assessment (co-payment) was not deducted.

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**Context:** The State pays nursing home providers for services to Medicaid clients. In some cases, the amount paid by the State should be reduced by an amount the nursing home should be collecting from the client. The portion to be paid by the client is referred to as the Cost of Care.

**Cause:** Logic errors exist in the electronic information system. From the advent of the MECMS development phase to the present, OMS has created 35 change control forms that have noted Cost of Care issues relative to claims processing. The noted deficiencies varied from incorrect Cost of Care amounts being deducted to no Cost of Care being applied to both new and adjustment claims. System users identified the following as possible causes:

- Ineffective system edits
- Illogical programming language regarding claim pricing
- Unsound application patches
- Errors in the placement of decimals during processing
- Interface problems from the Automated Client Eligibility System (ACES) to WELFRE/MECMS resulting in information not carrying over

**Effect:** Overpayments to providers

**Recommendation:** We recommend that the Department close all “open” change control forms regarding Cost of Care. We recommend correction of the logical errors in the MECMS system and recovery of overpayments previously made to providers.

**Management Response/Corrective Action Plan:** *The Department of Health and Human Services agrees with this finding.*

*A change control form was created for this issue (CCF #20060125-5) and was implemented in the first quarter 2006. Cost of Care is appropriately being deducted from nursing home claims at this time.*

*There are other issues related to cost of care and co-payments that are being addressed in a MECMS development initiative – these errors have been scoped and technical requirements have been drafted, and is scheduled for implementation in January 2008.*

*Nursing Homes are cost settled through DHHS Audit division and with the assistance of the Adjustment Unit; the audit scope is being expanded to include incorrectly paid claims, including claims where cost of care was not deducted.*

**Contact:** Robin Chacon, DHHS - Office of MaineCare Services (OMS), Claims Director, 287-2769

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(13)

**Finding Title:** Inadequate control system over multiple authorized rates

**Prior Year Finding:** No

**CFDA:** 93.775, 93.777, 93.778

**CFDA Title:** Medicaid Cluster

**Federal Award:** 05-0505ME5028, 05-0605ME5028

**Federal Agency:** U.S. Department of Health and Human Services

**State Department:** Health and Human Services (DHHS)

**Bureau:** Office of MaineCare Services

**Finding Type:** Internal control and compliance

**Compliance Area:** Allowable costs/Cost principles

**Known Questioned Cost:** \$23

This is the federal portion of an overpayment made to a provider

**Likely Questioned Cost:** \$503,957

The likely questioned cost was computed by applying the sample error rate of approximately 0.29% to expenditures of \$172.6 million of Mental Health and Mental Retardation Medical Payments.

**Criteria:**

- OMB Circular A-87
- MaineCare Benefits Manual, Chapter III §41, Day Treatment Services
- MaineCare Benefits Manual, Chapter III §24, Day Habilitation Services for Persons with Mental Retardation

**Condition:** The automated claims billing system does not have adequate internal controls in place to ensure that providers of certain services are being paid the correct amounts by the State. DHHS establishes multiple payment rates within the same procedure code. There is no control to prevent a provider from using billing rates that are higher than the authorized rates for specific service levels.

**Context:** Our sample contained two such transactions. One was billed and paid correctly. The second was paid using an unauthorized, expired rate.

**Cause:** Inadequate controls over the use of procedure codes and procedure code modifiers

**Effect:** Medicaid costs increased due to billing errors or intentional misuse of payment rates within the same procedure code.

**Recommendation:** We recommend that the Department develop the use of procedure codes and procedure code modifiers that will ensure providers are paid correct amounts for services.



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**Management Response/Corrective Action Plan:** *The Department of Health and Human Services agrees with this finding.*

*The current MMIS system does not allow for multiple authorized rates for the same provider location; therefore, when multiple FSD rates are authorized, the highest rate is loaded into the MMIS system. The contract includes a Summary of Services which lists each member and the rate the provider is approved for that member.*

*For Section 24, Day Habilitation Services, the DHHS Audit cost settlement report corrects all of the issues cited in this finding, and the CMS 64 report is adjusted appropriately. DHHS believes this is an adequate control to mitigate the risks cited in this finding.*

*For Section 41, Day Treatment Services, there is currently one provider that has two rates on MECMS for that provider ID. During fiscal year 2008, OMS will be reviewing options to correct this situation.*

*Additionally, for other programs that are not cost settled, the Department will review options to correct similar situations, as they exist.*

**Contact:** Robin Chacon, DHHS - Office of MaineCare Services (OMS), Claims Director, 287-2769

(14)

**Finding Title:** Lack of effective policies and procedures to address Medicaid recipient fraud

**Prior Year Finding:** No

**CFDA:** 93.775, 93.777, 93.778

**CFDA Title:** Medicaid Cluster

**Federal Award:** 05-0505ME5028, 05-0605ME5028, 05-0505ME5048, 05-0605ME5048

**Federal Agency:** U.S. Department of Health and Human Services

**State Department:** Health and Human Services (DHHS)

**Bureau:** Office of Integrated Access and Support (OIAS)

**Finding Type:** Internal control and compliance

**Compliance Area:** Special tests and provisions

**Known Questioned Cost:** None

**Likely Questioned Cost:** None

**Criteria:** Program Integrity: Medicaid (42 CFR §455); Title 22 MRSA §13

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**Condition:** DHHS does not have methods and criteria for identifying suspected Medicaid recipient fraud cases. Policies and procedures for investigating and referring suspected fraud cases to law enforcement authorities are insufficient.

OIAS determines client eligibility for the Medicaid program. OIAS does not have the authority or responsibility for determining if the recipient received Medicaid services to which they were not entitled. Because DHHS does not have a policy regarding client overpayments for Medicaid services, overpayments are not quantified, tracked or recovered. Furthermore, because DHHS does not have a policy to assess whether the misrepresentation was intentional, no follow-up of potential abuse or fraud resulting from eligibility determinations takes place.

DHHS Fraud Investigation and Recovery Unit (FIRU) is a part of OIAS. Although allegations of Medicaid recipient fraud may be referred to it by the Program Integrity Unit (PIU), FIRU does little with them. It focuses its work on referrals or overpayments made in the Food Stamp and Temporary Assistance for Needy Families (TANF) programs. Although FIRU adds potentially fraudulent Medicaid recipient claims to overpayment claims prosecuted in these two programs, there is otherwise no effort to identify Medicaid recipient claims. 42 CFR §455.14 requires that the Medicaid agency conduct a preliminary investigation whenever a complaint or identification of a questionable practice is received. Also, 22 M.R.S.A. §13 established FIRU to investigate all fraud involving funds administered by DHHS.

**Context:** The Medicaid program is a \$2 billion program that is generally (except for eligibility) administered by the Office of MaineCare Services (OMS).

**Cause:**

- There is a lack of communication and coordination of efforts to identify and investigate Medicaid fraud by various responsible organizational units (i.e. OIAS, OMS, PIU, DHHS Financial Management Services, FIRU, Medicaid Eligibility Quality Control Unit (MEQC) and the Medicaid Fraud Control Unit that is located in the Office of the Attorney General).
- OIAS does not have the authority or responsibility to determine if the recipient received Medicaid services to which they were not entitled.
- FIRU reports difficulty in obtaining information regarding Medicaid overpayments, claims paid, and services provided, which has prevented it from pursuing Medicaid cases.
- Although allegations of Medicaid recipient fraud may be referred to FIRU by the Program Integrity Unit (PIU), it does little with them.
- There is a lack of DHHS policies regarding quantifying, tracking and recovering client overpayments for services.
- DHHS does not have a policy to assess whether the recipient's misrepresentation of information was intended to abuse or defraud the Medicaid program.
- There is no follow-up of potential abuse or fraud resulting from eligibility determinations.

**Effect:** Inadequate referral and follow-through on potential fraud means that program funds are not available for legitimate claims and overall Medicaid costs are higher than necessary.

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Individuals who obtain benefits incorrectly, either by intentional or unintentional means, are not identified nor prosecuted; they suffer no consequences. This perpetuates abuse.

Because the established policies and procedures do not adequately address recipient unintentional or intentional misrepresentation, there is no means to quantify the amount and pervasiveness of potential loss or to determine particular areas of higher risk. DHHS could not quantify any Medicaid recoveries relating to client eligibility. DHHS personnel noted minimal recoveries that resulted from prosecution of individuals who received direct payments for falsified mileage reimbursement records and falsified consumer direct attendant records.

**Recommendation:** We recommend that the Department:

- Establish policies and procedures to address authority and responsibilities for personnel involved in all phases of the fraud investigation and recovery processes, including intentional and unintentional misrepresentation of information for eligibility, the identification of ineligible individuals, quantification of the amount of the loss or overpayment, procedures to record and track overpayments and recoveries, and referral to law enforcement officials.
- Consider initiating amendments to State law to provide a means to recover the value of medical benefits provided as the result of intentional or unintentional misrepresentation of personal circumstances by the recipient.
- Establish procedures for the FIRU unit or other responsible personnel to identify potentially fraudulent cases resulting from intentional client misrepresentations and to efficiently access Medicaid claims transactions to determine client claims history for the purpose of determining the potential loss or overpayments.
- Consider establishing a single unit or division to investigate and coordinate all fraud investigation and recovery activities. This unit should be independent and free of influence from program operations.

**Management Response/Corrective Action Plan:** *The Department of Health and Human Services agrees with the recommendations around establishment of policies and procedures.*

*OIAS does have the authority and responsibility for identifying and investigating recipient fraud, evidenced by the relevant section (sec. 1132) of the MaineCare Eligibility Manual:*

### **1132 REFERRAL TO THE FRAUD INVESTIGATION UNIT**

*If it appears that a recipient has purposely misrepresented actual circumstances (such as living arrangement, income, or assets) in order to receive Medical Assistance, and the individual would not have been eligible to the same extent had the proper information been available at the time of application, redetermination of eligibility, or within 10 days of the change in circumstances, a referral to the Fraud Investigation Unit will be made. (See Section 1420.).*

*The report will include:*

- I. a detailed explanation of the misrepresentation and the effect it had on eligibility.*
- II. a claims history indicating the services that should not have been paid.*

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*Complaints received directly by the Fraud Investigation Unit from the community will be screened through the Director of the Medical Assistance Program to see if the individual is an active or former recipient. The Director will check the status and direct the Fraud Investigation Unit to the proper regional office if eligibility has existed. The Fraud Investigation Unit will then share its information with the regional office which in turn will determine the effect this information has on eligibility.*

*The Department agrees that policies and procedures should be established to address authority and responsibilities for personnel involved in all phases of the fraud investigation and recovery processes. The Department also agrees that referrals for TANF and Food Stamps should be reviewed for Medicaid component, as applicable.*

*Contact: Barbara VanBurgel, Director, Office of Integrated Access and Support, 287-3106*

(15)

**Finding Title:** Re-determinations not timely

**Prior Year Finding:** No

**CFDA:** 93.775, 93.777, 93.778

**CFDA Title:** Medicaid Cluster

**Federal Award:** 05-0505ME5028, 05-0605ME5028

**Federal Agency:** U.S. Department of Health and Human Services

**State Department:** Health and Human Services (DHHS)

**Bureau:** Office of Child and Family Services

**Finding Type:** Internal control and compliance

**Compliance Area:** Eligibility

**Known Questioned Cost:** None

**Likely Questioned Cost:** None

**Criteria:** 42 CFR §435.916

**Condition:** DHHS did not complete timely re-determinations of client eligibility for two of 60 Medicaid non-pharmacy clients who we tested. Both exceptions were Foster Care Title IV-E cases, of which our sample included five. Controls over Medicaid eligibility determinations for cases administered by Division of Regional Operations (DROMBOS) are not adequate.

**Context:** Annual client eligibility reviews are required in order to ensure continuing client eligibility to participate in Medicaid.

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**Cause:** No established procedures for timely client eligibility reviews.

**Effect:** Noncompliance with annual eligibility review requirements may result in payments to ineligible participants and unnecessary costs to the program.

**Recommendation:** We recommend that the Department complete all reviews on a timely basis, including those conducted by DROMBOS.

**Management Response/Corrective Action Plan:** *The Department of Health and Human Services agrees with the recommendation that all eligibility reviews be completed on a timely basis.*

*In the spring of 2007, the staff who complete all eligibility reviews for children in foster care transitioned from the Division of Regional Operations to the Office of Child and Family Services (OCFS). It is a clearly articulated expectation of staff that all eligibility determinations be completed timely.*

*These twelve Financial Resource Specialists are supervised by the Title IV-E Program Specialist. As part of the transition, systems have been established to ensure timely reviews are made in all cases. Staff will continue to be reminded of the important connection between timely determinations, Medicaid, and its effect on funding. Additionally, staff attend monthly meetings and these, along with individual supervision, focus on the importance of timely reviews.*

**Contact:** Dulcey Laberge, DHHS - Division of Public Service Management, Director, 287-5064

(16)

**Finding Title:** State Income and Eligibility Verification System (IEVS) data exchange noncompliant

**Prior Year Finding:** 05-67

**CFDA:** 93.775, 93.777, 93.778, 93.767, 93.558, 10.551, 10.561

**CFDA Title:** Medicaid Cluster

State Children's Insurance Program (SCHIP)

Temporary Assistance for Needy Families (TANF)

Food Stamp Cluster

**Federal Award:** 05-0505ME5028, 05-0605ME5028

05-0505ME5048, 05-0605ME5048

ME TANF05, ME TANF06

2005IS251444, 4ME400401

**Federal Agency:** U.S. Department of Health and Human Services;  
U.S. Department of Agriculture

**State Department:** Administrative and Financial Services (DAFS)  
Health and Human Services (DHHS)

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**Bureau:** Office of MaineCare Services (OMS)  
Office of Integrated Access & Support (OIAS)  
Office of Information Technology (OIT)

**Finding Type:** Internal control and compliance

**Compliance Area:** Eligibility

**Known Questioned Cost:** None

**Likely Questioned Cost:** None

**Criteria:** 42 CFR §435.910  
45 CFR §205.55  
42 CFR §435.948(e), 435.953  
42 USC §1320b-7

**Condition:** DHHS lacks adequate procedures to make full use of the information obtained through data exchanges and to comply with federal regulations. The Social Security Administration (SSA) transmits data in the form of bi-weekly BENDEX and daily SDX reports to the DHHS for use by the Income and Eligibility Verification System (IEVS) as part of its automated determination of applicant/client eligibility status.

- Caseworkers are not provided with the BENDEX data to establish the client Date of Death. The IEVS data is therefore unavailable to prevent a determination of eligibility. Caseworkers rely on family members or nursing facilities to advise them when a client is deceased.
- DHHS caseworkers do not review the monthly BENDEX error report for incorrect Social Security Numbers (SSN). No automated SSN mismatch reports are generated by ACES from the daily SDX exchange to flag potential SSN discrepancies for resolution by caseworkers.
- DHHS regional supervisors do not use consistent methodologies to review and maintain data obtained from the Internal Revenue Services. DHHS directed supervisors to review the material on a sample basis and to review any effect on clients eligible only for MaineCare as the last priority, after TANF and Food Stamps.
- DHHS did not change its State Verification and Eligibility System (SVES) data transmissions to SSA to comply with their guidelines; prior year audit testing noted that some transmissions were rejected due to coding differences.
- ACES erroneously re-opened Supplemental Security Income (SSI) related cases, previously closed by OIAS, based solely on the identification of a new client SSN provided by the daily SDX exchange.

**Context:** The State uses a single automated system, Automated Client Eligibility System (ACES), to determine individuals' eligibility for major welfare programs, including MaineCare, TANF, Food Stamps, and SCHIP. The State is required to verify the social security number (SSN) and other information of all recipients of federally-funded aid, and to obtain and use the

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related data provided by the SSA in subsequent information exchanges to the State to determine the continuing eligibility of individuals.

**Cause:** The data exchanges provide a multitude of data and reports for OIAS's use. Standardized procedures are necessary to ensure consistent and appropriate consideration of all information received. We noted the following:

- Supervisory review procedures are inconsistent because DHHS has not provided supervisors with specific training or guidance to review the IRS data.
- Caseworkers do not review the BENDEX report for incorrect SSN due to time constraints and because DHHS has not corrected a programming error that causes the report to erroneously identify many potential mismatches.
- Policy has been established but procedures are not in place to provide assurance that potential SSN, income, and name errors flagged in ACES reports will be reviewed for resolution by caseworkers.
- The State has not adhered to data coding requirements for State Eligibility Verification Systems (SVES) outbound transmissions.
- ACES does not generate reports for case workers' use for either BENDEX Date of Death information or SDX potentially incorrect Supplemental Security Income Social Security Numbers.

**Effect:** Resolution of potential SSN mismatch errors from these exchanges is critical for case management of Medicaid and SCHIP cases, as well as for TANF and Food Stamps. This is especially true for individuals whose Medicaid cases are SSI related, because they are determined Medicaid eligible based solely upon receipt or eligibility for SSI. DHHS never re-determines client eligibility for such cases because the Department relies on reports generated by ACES to alert caseworkers that clients may no longer be eligible. Also, because client data contained in the SSA systems is primarily SSN driven, discrepancies between SSA and DHHS records must be resolved. Inconsistent use of transmitted data may result in the following.

- Case files may not be closed and benefits not discontinued in a timely manner
- Unresolved potential SSN, income, and name errors in ACES and in any other systems to which the same client information is communicated
- Known programming errors in the reports lessen user confidence in them and cause them not to be used
- Caseworkers must rely on nursing homes and other facilities who receive MaineCare benefits, or relatives, to notify them of a client's death. These facilities do not always track or report this information in a timely manner and may continue to receive monthly medical payments as a result.
- Inconsistent practices to utilize IRS data create the risk that the information may not be utilized as intended or that it may be unintentionally disclosed

**Recommendation:** We recommend that the Department establish policies and procedures to consistently use SSA and IRS data during the client eligibility determination process; to prevent payments to ineligible clients/providers; and to comply with federal regulations.

**Management Response/Corrective Action Plan:** *The Department of Health and Human Services and the Department of Administrative and Financial Services agree with this finding.*

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*During fiscal year 2007 many of the reports stated in this finding have been corrected. OIAS staff, supervisors and program administrators are provided instructions on handling all IRS information. During fiscal year 2008, OIAS will review the instructions and enhance the policies and procedures as needed.*

**Contact:** Brian Guerrette, DHHS/OIT/DAFS, Systems Section Manager, 287-1748  
Barbara VanBurgel, Director, Office of Integrated Access and Support, 287-3106

(17)

**Finding Title:** Client eligibility determinations incorrect and differing between systems

**Prior Year Finding:** No

**CFDA:** 93.775, 93.777, 93.778, 93.767

**CFDA Title:** Medicaid Cluster

State Children's Insurance Program (SCHIP)

**State Program:** Drugs for the Elderly, Maine Rx

**Federal Award:** 05-0505ME5028, 05-0605ME5028

05-0505ME5048, 05-0605ME5048

**Federal Agency:** U.S. Department of Health and Human Services

**State Department:** Administrative and Financial Services (DAFS)

Health and Human Services (DHHS)

**Bureau:** Office of MaineCare Services (OMS)

Office of Integrated Access & Support (OIAS)

Office of Information Technology (OIT)

**Finding Type:** Internal control

**Compliance Area:** Eligibility

**Known Questioned Cost:** None

**Likely Questioned Cost:** None

**Criteria:** OMB Circular A-102 Common Rule, 45 CFR §92.20; 42 CFR §433.32(a); 42 CFR §433.112, §433.116, §433.117, §433.119, and §433.131

**Condition:** Controls are inadequate to assure that medical claims from providers are paid only for individuals who are eligible for the Title XIX Medicaid and XXI State Children's Insurance Program (SCHIP) programs.

DHHS uses two automated eligibility systems: Automated Client Eligibility System (ACES) and Welfare Information System (WELFRE). ACES is a real time system that receives various data feeds and automatically acts on information entered to determine eligibility and enroll individuals in programs for which they qualify. WELFRE is another eligibility system, which



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remains necessary to link ACES to the Maine Claims Management System (MECMS) and to the Maine Point of Purchase System for prescription drugs (MEPOPs.) WELFRE allows data entry but requires human action to determine eligibility and enroll individuals. MECMS does not pay claims based on the eligibility status shown in either ACES or WELFRE for a particular service date, but on the member eligibility tables that are created within MECMS by applying Client Network Services, Inc. (CNSI) Business Rules and Logic to information flowing through the system interfaces. Because the process transfers all records from WELFRE, about 72% of the records are for deceased or otherwise ineligible individuals.

**Context:** We tested the sufficiency of controls over the interface/transmission of client eligibility data and the integrity of this data from system to system. We tested the reasonableness of Medicaid program client count data maintained in ACES and WELFRE, and the reference tables of the Medicaid Management Information System (MMIS)/MECMS, which are used to process claims, prepare reports, and administer the program in OMS. The data processing we tested resulted in the following:

- In the fall of 2005, DHHS certified many individuals, some deceased, as eligible for DHHS programs for which they had not applied. DHHS automated systems generated \$10.00 State Supplemental checks to a number of them. Many of those who received the checks, or their surviving relatives, contacted DHHS to complain: they wanted to know how DHHS had obtained their personal information; why very old addresses were being used; and why checks were issued to deceased relatives. Once aware of the problem, DHHS employees stopped some checks from being delivered by changing addresses in ACES from the individuals' addresses to regional DHHS office addresses. Caseworkers repeatedly closed some of the cases but the programming logic within ACES caused them to be re-opened.
- DHHS relies on family members or nursing home employees for notice of death. We noted one overpayment to a nursing home after the death of a client.
- ACES opened duplicate cases and generated unwarranted \$10 State supplemental checks due to incorrect entry of social security numbers that did not match those in Social Security Administration income and eligibility (IEVS) data transmissions. Even if caseworkers closed the duplicate cases, the system automatically re-opened them each time the interface ran. ACES does not generate a Social Security Data Exchange (SDX) error report of potential SSN errors.
- Eligibility Start Dates in ACES were not always logical, because some were much later than end dates. These dates were entered by OIT in order to flag incorrect eligibility coverages. However, other system users may not recognize that the data is intentionally illogical.
- MECMS and ACES client eligibility data do not always agree. Seven of the 40 oldest Medicaid clients (18%) examined in June 2006 MECMS records were not eligible: five were deceased (one in 2002, two in 2003 and one in 2005); two were not eligible in ACES during the year. DHHS did not close ACES eligibility for two of the deceased for more than three years; the third is still open.
- The Office of MaineCare Services (OMS) does not research warning or error messages generated during creation of the member eligibility tables; only "fatal errors" prevent

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clients from being included in the MECMS eligibility tables. Additionally, the process may not be compliant with federal certification requirements because the results do not seem logical according to OMS personnel. For example, the two stage process for June 2006 showed a higher client count for the second stage than the first.

- OMS is attempting to add Social Security Administration income and eligibility (IEVS) data exchanges to MECMS that duplicate functionality that OIAS already has in ACES.

### **Cause:**

- On August 7, 2005 OIAS performed a “data dump” moving information of the State funded Drugs for the Elderly and MaineRx programs from the legacy WELFRE system to ACES. When the information was housed in WELFRE, OIAS determined eligibility manually, based on information from individuals applying for assistance. When the data dump occurred, ACES automatically processed the old data from WELFRE, resulting in the unwanted and erroneous eligibility determinations and check issuances.
- Incorrect entry of social security numbers and lack of error reporting caused ACES to open duplicate cases, even after manual attempts to close the case. Programming causes cases to reopen repeatedly.
- The causes for the MECMS member eligibility table logic discrepancies are unknown at this time because CNSI did not document the code used to generate the reports that result in the creation of the monthly client files and the person who wrote the code left the company.

**Effect:** The nature of the programs is such that, for the most part, although there were errors in eligibility, they did not result in overpayments. The overpayments that did occur were for small amounts and, other than one, were for direct payments to individuals and not overpayments for medical services provided.

The client eligibility data recorded in the major DHHS program systems should be the basis for all payments charged to federal and State programs administered by the Department at some level; therefore systemic errors may have a material impact to financial statements in which related expenditures are ultimately charged. The reasonableness of this data should, therefore, provide some assurance that OMB A-133 eligibility and allowable cost/activity requirements were met, in regard to federal programs administered under MaineCare.

Some methods used by OIAS to systematically re-determine the program eligibility of individuals in ACES solely based on all data recorded in the WELFRE system or by the override of ACES systematic rules (the “rules engine”) impacts the integrity of client eligibility data recorded in ACES as well as the payment systems that receive this information. Furthermore, the family members of some deceased persons on behalf of whom eligibility was determined in this method were forced to experience unnecessary emotional distress as a result, while others may have ignored letters and payments sent in error.

For a real-time system, like ACES, which interfaces with a number of systems on a regular basis, it is not reasonable that OIT personnel run “data fixes” to intentionally create illogical start dates for client program eligibility, in an effort to make them readily identifiable to caseworkers. Some systems and reports obtain client eligibility data from ACES by start date and some obtain

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it by end date to determine or account for DHHS program participation, and there is no guarantee that these dates will always be viewed in the same context.

The Social Security Administration has an agreement with the State OIAS operations that the data from IEVS (SDX/BENDEX/Buy-In) interfaces is to be used to facilitate client eligibility determinations on a large scale basis (in ACES). If utilized without complete individual client case knowledge or appropriate OIAS caseworker review, efforts by OMS to add this functionality to MECMS seem duplicative and potentially detrimental to the integrity of client member reference tables used by the MMIS (MECMS) system operations for the processing of claims for payment.

**Recommendation:** We recommend that the Department:

- Immediately establish a means to adequately trace the Departmental activities related to the distinct federal and State funded programs which are administered under the single catch-all entity (MaineCare).
- More clearly define and consistently support the coordination of specific roles assigned to the different agencies, internal and external to the Department, responsible for the administration of all DHHS programs, including system operations carried out by DAFS/OIT.
- In order to ensure the continuity of operations and the provision of vital services, we recommend that the Department immediately establish an effective means to comply with IEVS requirements that has been established in documented Department policies and procedures.
- Establish policies to provide assurance that IEVS information will be consistently and actively used during the client eligibility determination process.

**Management Response/Corrective Action Plan:** *The Department of Health and Human Services agrees with the finding, and offers the following:*

- (1) The Department agrees that the Maine RX/DEL conversion done in August 2005 increased the possibility of erroneous checks being generated due to existing issues with the SDX interface. The Department has taken steps to improve the filters on the SDX interface. Based on the filters, the Department will create suspense records for case worker review rather than automatically opening a new case. Currently, when the worker finds that a duplicate case was opened, the worker is instructed to correct the mismatched data so that when information from SDX is sent to ACES again, it will not create a duplicate case.*
- (2) The Department does rely on family members, yearly reviews or notification from the facility for notices of death. There is an ACES report, CME 007 – “Cases Where BENDEX Shows Client Deceased.” This is populated from the BENDEX inbound interface. Staff still need to follow up to confirm data on this report as it is not always accurate.*
- (3) System start dates that are much later than the end dates in ACES is a design mechanism to invalidate a case record.*

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- (4) *There has been an issue where client eligibility data in MECMS and ACES does not agree. This can sometimes result in cases being closed in ACES and not in WELFRE / MECMS. This flaw has been identified and is being corrected.*
- (5) *A Steering Committee has been established to oversee WELFRE repairs, resolve open issues and put manual cross checks in place in the interim. The Committee will also define our interface strategy with the Fiscal Agent which may include a direct interface between the Fiscal Agent and ACES, eliminating WELFRE.*

**Contact:** Tom Keyes, DHHS – OIAS, Deputy Director, 287-2310

(18)

**Finding Title:** Reported client counts inaccurate

**Prior Year Finding:** No

**CFDA:** 93.775, 93.777, 93.778

**CFDA Title:** Medicaid Cluster

**Federal Award:** 05-0505ME5028, 05-0605ME5028

**Federal Agency:** U.S. Department of Health and Human Services

**State Department:** Health and Human Services (DHHS)

Administrative and Financial Services (DAFS)

**Bureau:** Office of Integrated Access & Support (OIAS)

Office of Information Technology (OIT)

Office of Medicaid Services (OMS)

**Finding Type:** Internal control and compliance

**Compliance Area:** Eligibility

**Known Questioned Cost:** None

**Likely Questioned Cost:** None

**Criteria:**

Standards for financial management systems: Accounting records; Internal control (45 CFR §92.20 (b)(2)(3))

**Condition:** DHHS is not able to support MaineCare client case counts included on various management reports. OIAS and OIT are responsible for correctly reporting client data on program eligibility; OMS does not perform tests to ensure the accuracy of client data.

- Client counts reported were not consistent between reports for the same period. Between two reports that should contain identical information, the case count totals varied by 876 cases; totals by county varied by as much as 6,000 clients.
- Client counts were overstated; reports included deceased clients. Client data provided by OIT-MECMS, OMS and OIAS included deceased persons: 335 in MECMS, 128 in OMS and 110 in OIAS ACES data.

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- DHHS could not replicate queries to support reported information and could not always tell what information was being included in each category.

The Automated Client Eligibility System (ACES) is not designed to systematically identify the individuals counted in management reports, requiring OIT personnel to query ACES for the data. However, the exact client data that ACES counts for each category identified in summary reports can not be traced to the underlying case records maintained in ACES. ACES coding does not clearly identify the State and federally funded programs for which individuals are eligible. Controls to ensure the accuracy of data provided as support are, therefore, inadequate. We note that the Department sometimes uses the term MaineCare synonymously with Medicaid, but MaineCare includes several other State and federally funded programs.

Version controls over reports run in ACES are inadequate. At times, client count reports are generated manually using an old and outdated version of the program script. To correct such an error, the report is re-run with the current script version. The client count report generated by ACES queries for May 2006 and October 2005 summaries were incorrect (about 71,000 less than typical for the month). OIT personnel did detect and correct the May 2006 report, but not the October 2005 report.

**Context:** ACES has evolved into the central intake and eligibility application for State and federal program assistance. OIT is responsible for the maintenance and functionality of ACES and the other computer systems used for the administration of all major DHHS programs.

OIT personnel, who run and review these reports, rely on the experience and observation of others to identify instances in which report results appear incorrect.

**Cause:** The system is not programmed to verify that individuals counted in management reports have underlying client records maintained in ACES. Version controls for summary reports are not in place.

**Effect:** Client count data is misstated and could not be traced to underlying records in ACES.

The individuals counted in these reports are used as the basis for Department-Wide cost allocations. Without adequate support or controls to provide assurance regarding the clients counted, only minimal reliance can be placed upon the accuracy of the cost allocations based upon ACES reporting of program client counts.

**Recommendation:** We recommend that the Department establish a means to consistently provide accurate eligible client count information for federal and State funded programs, which are administered under the single catch-all entity MaineCare.

**Management Response/Corrective Action Plan:** *The Department of Health and Human Services and the Department of Administrative and Financial Services partially agree with this finding.*

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*We are in agreement that there are known problems in the sharing of data between ACES, WELFRE and MECMS and we have projects under way addressing some of these issues. The projects are due for completion summer 2008.*

*However we disagree with part of the finding where the reports examined should all yield the same counts/data. The reports identified in this audit are designed to meet specific needs of OIAS and look at the data in different ways. Certain programs may be included or excluded as needed and counts may be produced at a case or client level. Some results cannot be reproduced because it is a point in time look at the data. Even if it isn't this type of report the retroactive eligibility associated with Medicaid will constantly change numbers for prior periods.*

**Contact:** Brian Guerrette, DHHS/OIT/DAFS, Systems Section Manager, 287-1748

**Auditor's Conclusion:** While we agree that summary reports can and should be structured to look at data in various ways, the reports that we examined contained data specific to Medicaid. The client counts should have agreed as the reports were generated within a few days of each other, from ACES data, for the same prior month period.

The finding remains as stated.

(19)

**Finding Title:** OMS unauthorized approval of non-timely filing

**Prior Year Finding:** No

**CFDA:** 93.775, 93.777, 93.778, 93.767

**CFDA Title:** Medicaid Cluster

State Children's Insurance Program (SCHIP)

**Federal Award:** 05-0505ME5028, 05-0605ME5028

05-0505ME5048, 05-0605ME5048

05-0405ME5021; 05-0505ME5021

**Federal Agency:** U.S. Department of Health and Human Services

**State Department:** Health and Human Services (DHHS)

**Bureau:** Office of MaineCare Services (OMS)

**Finding Type:** Internal control and compliance

**Compliance Area:** Period of availability

**Known Questioned Cost:** None

**Likely Questioned Cost:** None

**Criteria:** 42 CFR §447.45(d)(1)

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**Condition:** OMS did not obtain official federal approval to change claims filing, correction and adjustment deadlines, although it verbally discussed the changes with the Centers for Medicare and Medicaid Services (CMS) prior to implementation.

On June 1, 2006, OMS issued an advisory to all MaineCare providers that extended the claims filing deadline from the “allowable 12 months” to 20 months from the date of service; under certain circumstances extended the claims filing deadline to 23 months; and provided a further extension if there was evidence of a prior timely filing. OMS also waived the requirement that corrected claims be resubmitted within one year, and also waived the 120-day requirement for adjustments.

**Context:** In January 2005, DHHS implemented a Medicaid claims payment management system (MECMS) that failed to work properly. The system failed to process many provider claims, could not issue timely payments or denials, and did not have the capacity to make claims adjustments within the required 120 days.

**Cause:**

OMS granted time extensions to providers because it believed these were necessary and appropriate due to the ongoing lack of MECMS functionality.

**Effect:**

- The General Fund may be liable for all claims processed in accordance with the June 1, 2006 advisory.
- The federal government could impose financial sanctions because the revised deadlines do not comply with federal requirements. However, a CMS official indicated that CMS was more interested in the State coming into compliance with federal requirements in January 2007, as promised.

**Recommendation:** We recommend that OMS continue working toward resolution with CMS and the MaineCare provider community.

**Management Response/Corrective Action Plan:** *The Department of Health and Human Services agrees with this finding.*

*In January of 2005, DHHS implemented a Medicaid Claims Payment Management System (MECMS) that failed to work properly. The system failed to process many provider claims, could not issue timely payments or denials, and did not have the capacity to make claims adjustments within the required 120 days.*

*In February of 2006, the State of Maine revised Chapter I of the MaineCare Benefits Manual Timely Filing Requirements to read:*

*1.10-2 Time Limit for Submission of Claims*

*The following time limits apply unless waived under special circumstances by the Department, such as the Department’s inability to process claims and/or adjustments:*

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*Providers have one (1) year from the date services are provided to bill the Department, regardless of when eligibility is verified. Since it is the responsibility of providers to verify eligibility, members may not be billed for covered services that have been denied by the Department for exceeding the one (1) year limit for claims submission because the provider did not verify eligibility.*

*During this time, OMS leadership was actively engaged in conversations with CMS and believed there was implied consent for waiver of the timely filing requirement based on significant deficiencies that hindered the timely processing of claims.*

*The 120-day rule for processing adjustments is a state only requirement:*

### *1.12-1 Underpayments*

*If a provider believes an underpayment has been made for covered services rendered, based upon policy and procedures as described in this Manual, the provider should accept and cash the check issued for the services provided. **The provider must request a review of payments within one hundred and twenty (120) days of the remittance statement date** or waive*

*Effective 2-2-06 any right to a review of that payment. The provider must request a review of the payment in writing and attach a copy of the remittance statement page indicating the underpayment.*

*Consequently, OMS exercised the right to waive this requirement due to the absence of system functionality to process adjustments in MECMS.*

*Initial timely filing conversations with CMS began in late 2005, to secure support to waive the timely filing limit due to system deficiencies and the inability to receive and process claims. In June 2006, OMS and DHHS leadership corresponded in writing to continue to pursue approval to extend timely filing requirements to 18 months for claims submissions. In a written response from CMS, it was acknowledged that OMS would notify providers of the expiration of this extension as of January 1, 2007. A listserv e-mail was sent to providers on December 29, 2006.*

*There are still deficiencies in the current MMIS system which prevent the timely processing of certain types of claims (i.e. hospital crossover claims) and discussions are continuing with CMS to identify these exceptions and explore workarounds to resolve these issues.*

**Contact:** Robin Chacon, DHHS - OMS, Claims Director, 287-2769



## MEDICAID CLUSTER

(20)

**Finding Title:** Third Party Liability collections and cost avoidance data not reported

**Prior Year Finding:** No

**CFDA:** 93.775, 93.777, 93.778

**CFDA Title:** Medicaid Cluster

**Federal Award:** 05-0505ME5028, 05-0605ME5028

**Federal Agency:** U.S. Department of Health and Human Services

**State Department:** Health and Human Services (DHHS)

**Bureau:** Office of MaineCare Services (OMS)

Office of Management and Budget

**Finding Type:** Internal control and compliance

**Compliance Area:** Reporting

**Known Questioned Cost:** None

**Likely Questioned Cost:** None

**Criteria:** Preparation of the Quarterly Statement of Third Party Liability (TPL) Collections and Cost Avoidance Form (§2500.3 Federal State Medicaid Manual)

**Condition:** DHHS did not report Third Party Liability (TPL) information to the Centers for Medicare and Medicaid Services (CMS) for the period January 1, 2005 to June 30, 2006. On September 30, 2006, DHHS reported the omitted information on a cumulative basis. DHHS still did not report required Cost of Avoidance information for most Medicaid activity.

**Context:** Medicaid is intended to be the payer of last resort. DHHS' TPL Unit ensures that all potential payers of medical services are requested to reimburse the program in order to offset expenditures. TPL recoveries and cost avoidance efforts directly result in millions of dollars in taxpayer savings for the Medical Assistance Program.

On an annual basis, the Division of Financial Management in the Center for Medicaid and State Operations extracts TPL cost avoidance and collections data reported by the States on a quarterly basis to CMS on the CMS-64 Report. The data is used by CMS central office and regional office personnel to monitor and evaluate the effectiveness of States' TPL activity based on the varying methods used for recoveries. In addition to TPL data, State-reported total computable medical assistance payment (MAP) data (exclusive of adjustments) are extracted and presented to show the total TPL to total expenditures for Medicaid services.

The State's new Medicaid Management Information System (MMIS) is still unable to generate cost avoidance data in terms of dollars saved; however, this data on behalf of pharmacy claims processed on the State's point-of-purchase system (MEPOPS) is available for reporting purposes.

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### **Cause:**

- Lack of a functioning TPL subsystem in the Maine Claims Management System (MECMS)
- Confusion over TPL reporting responsibilities and restructuring of the State Medicaid agency

**Effect:** The program's financial reports have been incomplete and potentially misleading. Monitoring and evaluation of TPL collection and cost avoidance have been diminished because information has not been reported. In addition, past and future efforts will continue to be hampered because (except for pharmacy related claims) the State has not yet developed systems and procedures resulting in the reporting of cost avoidance.

### **Recommendation:** We recommend that the Department:

- Develop and implement the needed change controls in MMIS in order to generate the necessary system critical reports denoting TPL collections and cost avoidance data.
- Timely communicate all TPL collections and cost avoidance data for inclusion in the program's quarterly expenditure report.
- Ensure that all duties are identified and re-assigned, if necessary, whenever there is an organizational change.

**Management Response/Corrective Action Plan:** *The Department of Health and Human Services agrees with this finding.*

- 1) *TPL will continue to use the current method of reporting collections by gathering and preparing a spreadsheet that calculates collection figures for each of the TPL recovery areas using the weekly WELFRE Member TPL Financial reports until such time as the Fiscal Agent TPL sub-system is available. Medical claim cost avoidance reports are being developed and tested at this time and should be available by 9/30/07. This information will be combined with the pharmacy cost avoidance information on future CMS64 reports and TPL will report the information that we have been unable to obtain until now for the previous quarters as soon as that information becomes available.*
- 2) *TPL will communicate collections and cost avoidance data to the individual involved in the preparation of the program's quarterly expenditure report within 21 days of the end of the quarter.*
- 3) *Reporting requirements have been documented, documentation will be kept current, and staff has been cross trained in order to ensure that all reporting duties are reassigned properly and timely in the event of a future organization change.*

**Contact:** Rossi Rowe, DHHS - Third Party Liability, Division Director, 287-1838

## MEDICAID CLUSTER

(21)

**Finding Title:** Medicaid financial reports do not satisfy requirements

**Prior Year Finding:** 05-30

**CFDA:** 93.775, 93.777, 93.778

**CFDA Title:** Medicaid Cluster

**Federal Award:** 05-0505ME5028, 05-0605ME5028, 05-0505ME5048, 05-0605ME5048

**Federal Agency:** U.S. Department of Health and Human Services

**State Department:** Health and Human Services (DHHS)

**Bureau:** Office of Management and Budget

**Finding Type:** Internal control and compliance

**Compliance Area:** Reporting

**Known Questioned Cost:** None

**Likely Questioned Cost:** None

**Criteria:** 45 CFR §92.20

**Condition:** DHHS reports of its expenditures for the Medical Assistance Program, Medicaid, are based largely on estimates rather than actual recorded expenditures. The State Medicaid Manual and other Centers for Medicare and Medicaid Services (CMS) guidance requires that only expenditures for which all supporting documentation is readily available and only actual recorded expenditures should be reported.

We tested the accuracy and propriety of the quarterly expenditure report for the quarter ended September 30, 2005 and noted the following:

- Certain State match amounts (also known as certified seed) totaling \$55 million were reported based on mathematical calculations with no supporting documentation.
- Waiver expenditures were not broken out, were not reported by fiscal year, and were improperly aggregated as current quarter expenditures.
- The allocation factors applied to prospective inpatient and outpatient hospital payments for reporting purposes were carried forward from a previous reporting period and were not adjusted to reflect current quarter activity.

For the audit period, the federal share of actual expenditures reported included approximately \$131 million in "Interim Payments," which consist of actual payments made to providers based on estimates, not actual provider claims.

**Context:** The federal government funds approximately 64% of the State's Medicaid program; the federal share of reported Medicaid expenditures is \$1.6 billion. DHHS was reorganized at the beginning of the fiscal year to include the previously separate Department that administered mental health, mental retardation and substance abuse programs. DHHS activated a new Medicaid claims management information system (MMIS) in January 2005, called the Maine Claims Management System (MECMS). That system did not meet all Medicaid requirements

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and caused significant disruptions in program operation. Many claims became suspended in the system, limiting payment and reporting of actual claims, and leading to payment based on estimates. At the end of fiscal year 2006, DHHS reported \$507 million as interim (estimated) payments. DHHS is now trying to recover those payments from the providers; \$184 million remains outstanding.

**Cause:** DHHS has used estimates to report “Certified Seed” for some time, in part because the actual expenditures were incurred by agencies outside of DHHS and the actual expenditure information was not readily available to program accountants. Also, DHHS believed that reporting the calculated estimate was acceptable to the federal oversight agency. We do not question costs as our analysis shows that actual qualifying matching expenditures appear to exceed the amount reported.

MECMS, implemented in January 2005, has not functioned properly and is incapable of generating reports that break out waiver expenditures by fiscal year. Further, the system cannot generate the hospital claims data used to calculate the payment ratios needed to distribute inpatient and outpatient hospital services for reporting purposes.

**Effect:** The cost of providing Medicaid services is obscured to the extent that financial reports include estimates, require adjustment, and are not final. Estimated payments may not represent actual claims, may require recoupment from providers and repayment of the federal share. Changes to reported expenditures have a direct effect on the program’s grant award for the next period; as expenditures are reduced, so is the award. The State is not in compliance with reporting instructions promulgated in §2500 of the State Medicaid Manual.

**Recommendation:** We recommend that the Department:

- Report actual State match expenditures.
- Segregate and separately report Medicaid waiver program expenditures .
- Determine the appropriate distribution percentages to be applied to prospective hospital payments and prepare the necessary CMS-64 adjustment to properly apportion costs .
- Reconcile the total amount paid in interim claims to the total actual claims submitted that warrant payment and then collect any overpayment or pay any additional amount due.

**Management Response/Corrective Action Plan:** *Recently there has been a significant change in the reporting capability within MECMS/MMDSS allowing for improved reporting including submission of the CMS 64. Below are management’s responses to the recommendations.*

**Recommendation:** We recommend that DHHS: Report actual State match expenditures

**Response:** *The calculation of State match amounts (certified seed) is a result of data being reported in two Approp Orgs yet combined for reporting purposes. Although a merged Department, the accounting structure still separates former BDS and DHS. The Department is researching options to obtain documentation that would support the certified seed reported on the CMS 64. For submission of fiscal year 2010/2011 biennial budget, all MaineCare expenses will be reflected in one Approp Org. Management has begun working with all parties to allow*

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*the accounting system to more closely represent the activities and reporting requirements of DHHS.*

**Recommendation:** Segregate and separately report Medicaid waiver program expenditures

**Response:** *Effective with the 3/31/07 CMS 64, the HIV Waiver expenditures were broken out by year of service as required by CMS including adjusting all prior 8 quarterly HIV Waiver reports. By 6/30/07 it is anticipated that all Childless Adult Waiver expenditures will be broken out by year of service including all prior quarter adjustments to meet CMS 64 requirements.*

**Recommendation:** Determine the appropriate distribution percentages to be applied to prospective hospital payments and prepare the necessary CMS-64 adjustment to properly apportion costs

**Response:** *With the development of MMDSS for MECMS the Department is developing the reporting capability that will produce the appropriate cost distribution for hospital PIP payments that will meet the needed CMS 64 requirements. The allocation process will be based on prior period cost reports as provided by the Department's Office of Audit.*

**Recommendation:** Reconcile the total amount paid in interim claims to the total actual claims submitted that warrant payment and then collect any overpayment or pay any additional amount due.

**Response:** *The Department provides CMS a quarterly reconciliation between the current balance of interims and the amount reported on the CMS 64. Interim payments were payments made in lieu of claims unable to process through MECMS upon its implementation in January of 2005. They were estimated based on prior claims payments. It is appropriate to ensure that providers were not overpaid (interim payments equal outstanding claims issues); or in the case of overpayment, ensuring that those funds are recovered and the expenditure offset by that recovery. There is a significant effort being conducted at OMS on interim payment reconciliation. That effort involves ensuring that any interim overpayments are returned to the State and the federal share returned to the federal government.*

**Contact:** Colin Lindley, DAFS, DHHS Service Center - MaineCare Finance, Director, 287-1855

## MEDICAID CLUSTER

(22)

**Finding Title:** HCBS Waiver annual report data can not be verified

**Prior Year Finding:** No

**CFDA:** 93.775, 93.777, 93.778

**CFDA Title:** Medicaid Cluster

**Federal Award:** 05-0505ME5028, 05-0605ME5028

**Federal Agency:** U.S. Department of Health and Human Services

**State Department:** Health and Human Services (DHHS)

**Bureau:** Adults with Cognitive & Physical Disability Services

**Finding Type:** Internal control and compliance

**Compliance Area:** Reporting

**Known Questioned Cost:** None

**Likely Questioned Cost:** None

**Criteria:** The State Medicaid Manual, §2700.6 et seq. requires the State to provide annual waiver assurance by submitting the Form CMS-372(S).

**Condition:** Information reported on the 372 report cannot be verified.

**Context:** A primary compliance requirement that a State must satisfy to participate in the Waiver is that the average costs for clients enrolled in the Home and Community Based Services Waiver program not exceed the average costs to Medicaid of providing services to clients in an Intermediate Care Facility. The 372 report includes the calculations that demonstrate compliance with the requirement. The report also summarizes Waiver expenditures by category and serves as a means for the federal government to monitor the Waiver.

**Cause:** After January 2005, the Muskie Institute obtained data for the report by querying the Maine Claims Management System (MECMS). MECMS has had issues in processing claims and lacks certain functionalities; data may not be complete. The Muskie Institute cautioned that the data it provided are "...as is" and should be used with appropriate caution." Because of MECMS processing issues, the State made "interim payments" to many of the Waiver providers based on estimated, not actual, costs.

**Effect:** Users of the report must consider it in light of the disclaimer associated with the underlying data and take into consideration any effect that the interim payments and other claims processing issues may have.

**Recommendation:** We recommend that the Department retain all supporting information for the report and appropriately caution any report users of the potential that it may be incomplete or contain errors or inaccuracies.

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**Management Response/Corrective Action Plan:** *The Department of Health and Human Services agrees with this finding.*

*CMS is aware of reporting issues. The Department is in the process of transferring responsibility for claims processing to a fiscal agent. As part of the transition, the fiscal agent will be required to provide standard Medicaid reports.*

**Contact:** *Jane Gallivan, DHHS - Program Systems Director, 287-4212*

(23)

**Finding Title:** Incorrect coding of crisis intervention services

**Prior Year Finding:** No

**CFDA:** 93.775, 93.777, 93.778

**CFDA Title:** Medicaid Cluster

**Federal Award:** 05-0505ME5028, 05-0605ME5028

**Federal Agency:** U.S. Department of Health and Human Services

**State Department:** Health and Human Services (DHHS)

**Bureau:** Adults with Cognitive & Physical Disability Services

**Finding Type:** Internal control and compliance

**Compliance Area:** Internal control and compliance

**Known Questioned Cost:** None

**Likely Questioned Cost:** None

### **Criteria:**

- MaineCare Benefits Manual §21.05-1, The Individual Plan should describe at a minimum:
  - 1) The medically necessary services to be provided
  - 2) The frequency of provision of the services
  - 3) The type of providers authorized/eligible to furnish the services
- MaineCare Benefits Manual §21.06-7 Crisis Intervention Services are required to be documented for the member in the provider's case record, including the scope, intensity, duration, intent and outcome of crisis intervention services.

**Condition:** The Home and Community Based Services Waiver Program established payment rates for one client who was the sole resident of the provider's program, by dividing the provider's estimated costs in two, coding half to Personal Support Services and half to Crisis Intervention Services, using 168 hours (7 days X 24 hours) each week as the base for each rate. The Individual Care Plan did not provide any breakdown of the amounts or frequencies of either service. The provider's budget for this one client included 8.5 full time equivalent personnel and estimated costs exceeded \$400,000.

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We confirmed that the services were provided. However, the provider's care notes did not distinguish between the categories of service although the total hours billed were supported. The provider expects the client to need 40 hours of service each 24 hour day; the provider charges any service over 24 hours a day to Crisis Intervention.

The Program paid the provider \$140,381 for "Crisis Intervention" for this client in fiscal year 2006.

**Context:** The Home and Community Based Waiver Program expends approximately \$221 million annually for about 2600 clients. Of that, Personal Support Services expenditures constitute about \$100 million for about 1,400 clients and Crisis Intervention Services about \$1 million for about 50 clients.

**Cause:** The Medicaid Claims Management System has a limit check of 168 hours each week for Personal Support Services. Since the limit check rejected the extra hours of services, two charge codes were used. One charge code was for Personal Support Services and the other for Crisis Intervention Services.

**Effect:** Miscoding the cost of services distorts accounting for the use of Waiver funds and the cost of providing services on both an individual and aggregate basis. Failure to complete Individual Care Plans adversely affects their ability to serve as a means to document the Program's identification of client needs and the allocation of sufficient, specific resources to meet them.

**Recommendation:** We recommend that the Home and Community Based Services Waiver Program code expenditures consistent with Waiver definitions and include all required components in each Individual Service Plan.

**Management Response/Corrective Action Plan:** *The Department of Health and Human Services agrees with the finding.*

*The Department agrees past limitations within the claims system may have resulted in some limited distortion of services provided. In the case cited, crisis services were billed when a 2:1 staff to consumer ratio was needed to prevent a likelihood of a crisis situation developing.*

*This fall the Department will be moving to a standardized and published rate system which will remove any appearance that rates having been arbitrarily set.*

**Contact:** *Jane Gallivan, DHHS - Program Systems Director, 287-4212*



## MEDICAID CLUSTER

(24)

**Finding Title:** Inadequate follow-up in cases of possible fraud

**Prior Year Finding:** No

**CFDA:** 93.775, 93.777, 93.778, 93.767

**CFDA Title:** Medicaid Cluster

State Children's Insurance Program (SCHIP)

**Federal Award:** 05-0505ME5028, 06-0605ME5028, 05-0505ME5021, 05-0605ME5021

**Federal Agency:** U.S. Department of Health and Human Services

**State Department:** Department of Health and Human Services (DHHS)

**Bureau:** Office of MaineCare Services

**Finding Type:** Internal control and compliance

**Compliance Area:** Special tests and provisions

**Known Questioned Cost:** None

**Likely Questioned Cost:** None

**Criteria:** 42 CFR §455 Subpart A; 42 CFR §457 Subpart I

**Condition:** A lack of staff has caused delays in the Program Integrity Unit's (PIU) investigations of possible provider fraud. As of June 30, 2006, PIU had 190 open provider investigations. Of the six that we examined, PIU was not actively working two and had no one available to conduct an "informal review" of a third.

**Context:** DHHS Medicaid and SCHIP expenditures exceed \$2 billion. The Program Integrity Unit has three remaining full time staff.

**Cause:** DHHS has reassigned two of five PIU staff to assist in other areas.

**Effect:**

- Fraud investigations are not timely
- Possible recoveries of federal and State funds are not obtained
- Possible fraudulent Medicaid provider billings are not detected

**Recommendation:** We recommend that the Department make sufficient resources available to the Program Integrity Unit so that it can timely complete its investigations.

**Management Response/Corrective Action Plan:** *The Department of Health and Human Services agrees with the recommendation.*

*In the fiscal year 2008/2009 biennial budget, the Legislature appropriated funds and positions to the Program Integrity Unit. This will enhance the current processes that DHHS uses to be*

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*compliant with the federal requirements for monitoring the Medicaid program for fraud and abuse.*

**Contact:** Herb Downs, DHHS, Office of Audit - Director, 287-2778

(25)

**Finding Title:** Controls do not ensure adequate program integrity and adequate surveillance and review

**Prior Year Finding:** 05-63

**CFDA:** 93.775, 93.777, 93.778, 93.767

**CFDA Title:** Medicaid Cluster

State Children's Insurance Program (SCHIP)

**Federal Award:** 05-0505ME5028, 05-0605ME5028, 05-0505ME5021, 05-0605ME5021

**Federal Agency:** U.S. Department of Health and Human Services

**State Department:** Health and Human Services (DHHS)

**Bureau:** Office of MaineCare Services

**Finding Type:** Internal control and compliance

**Compliance Area:** Special tests and provisions

**Known Questioned Cost:** None

**Likely Questioned Cost:** None

### Criteria:

- 42 CFR §455, §456, §457 (Subpart I)
- MaineCare Benefits Manual, Chapter I §1.17-1.18

**Condition:** DHHS does not have adequate internal controls in place to ensure the ongoing evaluation, on a sample basis, of the need for and the quality and timeliness of Medicaid services. DHHS does not have a post payment review process that allows State personnel to develop and review recipient and provider service profiles; nor to identify exceptions so that misutilization practices can be corrected.

**Context:** DHHS Medicaid and SCHIP expenditures amount to approximately \$2 billion. Utilization controls are necessary to safeguard against unnecessary or inappropriate use of services.

### Cause:

- The Surveillance Utilization Review (SURS) subsystem of the State's new claims processing system is not currently functional
- Lack of specialized software

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### **Effect:**

- Noncompliance with utilization control requirements
- Impaired ability to identify unusual payments that may result in failure to recover inappropriate payments

### **Recommendation:** We recommend that the Department:

- Fully implement the SURS subsystem as a core Medicaid Management Information System (MMIS) subsystem.
- Develop a post-payment review process that reviews recipient utilization and provider service profiles and identifies exceptions to correct misutilization practices.
- Procure specialized software to allow the SURS unit to download and convert data from the claims processing system for subsequent analytical purposes.

**Management Response/Corrective Action Plan:** *The Department of Health and Human Services agrees with this finding.*

*DHHS agrees that the current claims system does not have the capability to produce the sampling reports needed to evaluate services. Meanwhile, DHHS is working with the Office of Information Technology to develop COGNOS cubes which will provide limited profile data (anticipated implementation date: Late 2007). As the Department transitions MECMS to a fiscal agent, it will ensure that a comprehensive SURS component be included (anticipated implementation date: Early 2008).*

**Contact:** Herb Downs, DHHS, Office of Audit - Director, 287-2778

(26)

**Finding Title:** Claims processing and information retrieval system deficient

**Prior Year Finding:** 05-03, 05-31, 05-56

**CFDA:** 93.775, 93.777, 93.778,

**CFDA Title:** Medicaid Cluster

**Federal Award:** 05-0505ME5028, 05-0605ME5028, 05-0505ME5048, 05-0605ME5048

**Federal Agency:** U.S. Department of Health and Human Services

**State Department:** Health and Human Services (DHHS)

Administrative and Financial Services (DAFS)

**Bureau:** Office of MaineCare Services (OMS)

Office of Information Technology (OIT)

**Finding Type:** Internal control and compliance

**Compliance Area:** Special tests and provisions

**Known Questioned Cost:** None

**Likely Questioned Cost:** None

## MEDICAID CLUSTER

**Criteria:** 42 CFR §433.10-§433.131; 45 CFR §92.20; Section 11300 State Medicaid Manual

**Condition:** DHHS has been unable to make the Maine Claims Management System (MECMS) function properly. Four of six core subsystems do not accomplish all federally required functions and objectives for a Medicaid Management Information System (MMIS). Deficiencies include the following:

- The Claims Processing Subsystem cannot:
  - Ensure that all input submitted is processed completely
  - Ensure that reimbursements to providers are rendered promptly and correctly
  - Provide a prompt response to all inquiries regarding the status of any claim
  - Identify Third Party Liability (TPL) and assure that Medicaid is the payer of last resort
- The Recipient Subsystem cannot support TPL recovery activities
- The Surveillance and Utilization Review (SURS) Subsystem cannot:
  - Develop a comprehensive statistical profile of health care delivery and utilization patterns established by provider and recipient participants
  - Use computerized exception processing techniques to perform analyses and produce reports
- The Management and Administrative Reporting Subsystem has limited ability to:
  - Report information to assist management in fiscal planning and control
  - Produce program data necessary for Medicaid reporting
  - Monitor third party liabilities and recoveries required by the State plan
- MaineCare reports are created outside of MECMS by “workarounds” designed by the University of Southern Maine, Muskie Center, under contract with DHHS
- From July 1, 2005 through June 30, 2006, OMS staff submitted 1,180 change control forms to the system developer to fix claim pricing errors, permission matrix problems, and edits that failed or were bypassed
- Examples of specific processing problems follow:
  - MR waiver claims rejected due to interface problems between MR Enterprise Information System and MECMS
  - Some claims processed through the Fund Exception Matrix with no assigned accounting string
  - Claims paid at the wrong federal financial participation (FFP) rate
  - Insufficient cycle summary reports on dollar amounts paid to program providers, funds used, and accounts debited or credited
  - Duplicate payments made to providers that could not be quantified
  - A high volume of Suspended claims
  - Inability to re-price Void and Adjustment claims
  - Untimely hospital cost settlements using non-current data
  - Incorrectly priced Part B Medicare crossover claims
  - Failed processing system edits, as well as edits set to “ignore”
  - Claims in processing failure status
  - Noncompliance with Health Insurance Portability and Accountability Act (HIPAA) claims format

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**Context:** Medicaid is a \$2 billion federally and State-funded program. The Claims Management Information System is essential to its operation.

**Cause:** DHHS converted to the new MMIS prematurely. The initial system breakdown can be attributed to the following:

- An inadequate system development effort
- Lack of a formal risk management process
- Lack of effective testing before going into production
- Procuring the services of a software vendor unfamiliar with the processing of medical claims

**Effect:** MECMS problems have severely inconvenienced Medicaid providers; they continue to incur additional expenses, while trying to be reimbursed for services rendered. System problems caused hundreds of thousands of provider claims to “suspend” or fail to completely process, causing providers not to be paid. To provide cash flow that would allow the providers to stay in business, the State issued “Interim Payments” that were intended to approximate normal payments. As of June 30, 2006, Interim Payments totaled approximately \$507 million. Lesser amounts continue to be paid in fiscal year 2007.

Interim Payments are not associated with actual claims. As the System started to process actual claims, some providers were overpaid, as they received both types of payments. The State is now attempting to reconcile the Interim Payments to actual provider claims: to determine how much is still owed providers and to recover overpayments. The State estimated that approximately \$21 million might not be collectable.

For two fiscal quarters, the federal government required the State to report not only the actual cash recoupments but also the amount of any provider agreements as adjustments on the State’s Medicaid quarterly financial reports. The reductions of expenditures will result in reductions of the State’s future Medicaid grant award and also the amount of federal cash available to be drawn.

The State is itself experiencing cash flow and budgetary concerns because of MECMS. The State’s General Fund temporarily absorbed the federal share of the \$56 million of provider agreements reported but not actually recouped. Also, the federal government refused to share in costs associated with the flawed implementation resulting in extra costs paid from State resources. In addition to the original project contractors, the State has engaged other consultants to assist with the implementation and also to make recommendations to restructure the Office of MaineCare services. Consultants now provide some of the ongoing management of MaineCare. Costs for one consultant exceed \$13 million; MECMS contractor and consultant costs to date are more than \$64 million. The System was originally expected to cost approximately \$16 million.

The State engaged an actuary to estimate its liability for Medicaid claims incurred but not paid (IBNP). At June 30, 2006, the actuarial estimate for IBNP (exclusive of hospital cost settlements) was \$520 million. The estimate included a 25% margin for adverse deviation, \$104

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million, due to the uncertainties associated with MECMS. The liability estimate was not reduced to reflect any Interim Payments due back to the State.

A federal audit questioned the ability of MECMS to correctly process claims. The federal auditors recommended that DHHS reprocess all Medicaid claims since conversion; the State responded that the recommendation was not practical and instead planned to rely on quality testing. The Centers for Medicare and Medicaid Services (CMS) has not issued a decision on the recommendation.

The ability of State agency personnel to complete their work has been adversely affected. Staff has been diverted to assist with stabilization efforts. Agency personnel have had no option but to use the new system, even while it continues to be developed.

DHHS has decided to transition claims management to a fiscal agent due to the persistent and unresolved System problems. That arrangement is expected to take three years to become operational. The State has reached agreement with the original contractor to continue to operate and to correct problems while the fiscal agent solution is put into place. Much of the MECMS development and design was not documented such that another contractor or the State could operate the System without continuing contractor involvement.

**Recommendation:** We recommend that the Office of MaineCare Services:

- Develop a detailed plan for transition to the new fiscal agent model being considered
- Develop a fallback capability during the transition
- Continue stabilization efforts so that MECMS provides for uninterrupted service
- Limit use of open-ended contracts; ensure that all contracts contain specific deliverables and provide for adequate DHHS oversight to ensure acceptable completion
- Implement the full complement of processing system cycle edits
- Generate a claims processing technical design plan
- Fully rectify or close all processing system change control forms (identifying system errors and inadequacies) currently in “open” status
- Investigate the status of each provider’s unprocessed and suspended claims and determine their respective overpayment amounts, if any
- Continue the formal recovery effort, which commenced in December of 2005, to recoup overpayments paid out in interim payments
- Develop the means to generate a report of duplicate payments made to providers and recoup any overpaid amounts
- Develop the means to generate the system reports critical to data control, provider cost settlements, and day-to-day management functions including the monitoring of program activity
- Fully resolve with the federal government their recommendation to reprocess MECMS claims
- Upon completion of a replacement processing system, migrate the rules engine and core subsystems to the new platform operated by the fiscal agent

**Management Response/Corrective Action Plan:** *DHHS agrees that the existing Medicaid Claims Management Information System (MECMS), implemented January 25, 2005 continues to*

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*operate deficiently and without necessary functionality for Third Party Liability recoveries and Program Integrity. The following actions have been taken to remedy the situation:*

- *In 2006, MaineCare Services was reorganized and directors were hired for key division areas: Customer Service, Claims, Communications, and TPL. Additionally, in January 2007, management analyst positions and Quality Assurance staff were added in the Claims Division, to transition analytical and QA work previously supported by a consulting firm. At this time, only one project management role is held by a consultant.*
- *With the cooperation of CMS, DHHS entered into an 18-month agreement with CNSI to implement nine system development initiatives to remedy major deficiencies in the current MECMS program. These initiatives include:*
  - *Interim Payment Recovery (IPR) Claims Hold – to assist in recovery of Interim Payments, implemented March 2007*
  - *J-Code Functionality – to allow OMS to comply with drug rebate requirements, implemented June 2007*
  - *Voided Functionality – to allow providers and OMS to void claims, to be implemented October 2007*
  - *Edits Processing Failure Initiative – to prevent claims from failing to process, resulting in “stuck” claims, to be implemented January 2008*
  - *Modifiers Initiative – to allow providers to bill HCPCS codes with appropriate pricing and descriptive modifiers, to be implemented January 2008*
  - *Co-pay and Cost of Care Initiatives – to process claims with correct consideration of co-pays and cost of care, to be implemented January 2008*
  - *Adjustments Functionality – to allow providers and OMS to adjust incorrectly paid claims, to be implemented March 2008.*
  - *Limits Initiative – to apply limits appropriately in the adjudication of claims, to be implemented in June 2008*
- *In addition to the development initiatives, CNSI is to support operation of MECMS and correcting ongoing issues through a structured Patch process. Approximately three patches are implemented monthly to correct smaller data or processing issues.*
- *During contract negotiations with CNSI in February 2007, OIT sent several staff members to CNSI Headquarters in Maryland, to fully train sufficient resources to take over system operations if needed. DHHS is confident that State staff could take over operations of MECMS if necessary. OIT continues to work with CNSI closely to automate systems operations maintenance functions to minimize dependence on human intervention.*

*Even with these development issues, it is highly unlikely that the existing MMIS system will ever support the missing functionality or be certified by CMS. Consequently, in January 2007, DHHS announced the decision to pursue a Fiscal Agent solution. Since that time, the Department has submitted the required documents with CMS to begin this process.*

*In July 2007, CMS provided the State with written approval of the accelerated procurement plan outlined in the PAPD. Under this approach, DHHS will perform a fit analysis, evaluate and select a vendor based on technical requirements in lieu of a full RFP process. This accelerated*

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*approach will allow the State to save five months in the procurement process, selecting a vendor by January 2008 and implementing a new MMIS system by January 2010.*

**Contact:** Robin Chacon, DHHS, OMS - Claims Director, 287-2769

### ***OIT Management's Response:***

*OIT agrees with the findings that the MECMS system is incomplete and not fully operating as intended. OIT concurs with the Department of Health and Human Services responses provided under their response to the findings.*

*In addition, OIT has reviewed the recommendations suggested related to IT functions. Specifically -*

- ***Generate a claims processing technical design plan.***  
*There are actually several technical design plans (TDPs) that, when pulled together, describe the design of the claims processing within MECMS. Missing is the higher level document that ties the different plans together. Because of the move to the fiscal agent, the State does not intend to add this higher level design document, unless time and priorities permit. Rather, energy will be focused on ensuring the new solution has the appropriate documentation.*
- ***Fully rectify or close all processing system change control forms (identifying system errors and inadequacies) currently in “open” status***  
*There are a large number of system change control forms (CCFs) currently in open status for MECMS. Part of the decision to move to a fiscal agent and thereby a new technical solution recognizes this fact, and the decision will be to only address (correct and close out) those that are of the highest importance to MECMS processing, DHHS business, and provider activities. As a result, the majority will be left in open state when we move to the fiscal agent. This approach was also solidified in the current contract with the MECMS vendor, CNSI.*
- ***Upon completion of a replacement processing system, migrate the rules engine and core subsystems to the new platform operated by the fiscal agent.***  
*This recommendation is counter to the approach now under way for the implementation of an MMIS with a new Fiscal Agent. The rules engine and core sub systems will not be used going forward. The specific rules implementation and subsystem outcomes will be requirements of the new fiscal agent, but they will not be required to operate the existing system.*

**Contact:** Richard Thompson, DAFS, OIT, Chief Information Officer, 624-7568



## MEDICAID CLUSTER

(27)

**Finding Title:** Inadequate security controls in Oracle Financials

**Prior Year Finding:** No

**CFDA:** 93.775, 93.777, 93.778

**CFDA Title:** Medicaid Cluster

**Federal Award:** 05-0505ME5028, 05-0605ME5028

**Federal Agency:** U.S. Department of Health and Human Services

**State Department:** Health and Human Services (DHHS)

**Bureau:** Office of MaineCare Services (OMS)

**Finding Type:** Internal control

**Compliance Area:** Special tests and provisions

**Known Questioned Cost:** None

**Likely Questioned Cost:** None

**Criteria:** Mechanized claims processing and information retrieval systems (42 CFR §433.110)

**Conditions:** We noted the following weaknesses in computer systems security practices:

- User access to Oracle Financials is not reviewed periodically. Users IDs for personnel who do not use the system are not revoked or deleted within a reasonable period.
- A workflow module, which would require electronic supervisory approval of transactions within Oracle Financials, had not been implemented. This allows State agency personnel to enter payments directly into the system, which subsequently are paid by the State's primary accounting system, without further review or authorization.
- Key programming staff at Client Network Services, Inc. (CNSI), the developer of the Maine Claims Management System (MECMS), has "super-user" access to Oracle Financials. Common controls in a data processing environment do not allow programming staff to have access to production systems.

**Context:** Oracle Financials is an intermediate accounting system used between MECMS and the State's primary accounting system, Maine Financial and Administrative Statewide Information System (MFASIS). One purpose of Oracle Financials is to combine MECMS claims into invoices and to record receivables that result from interim payments to provider; it is also used to make other non-claim payments.

**Cause:**

- A number of new user IDs were established when the Oracles Financials system was implemented with the expectation that certain personnel would continue to require access to the system. These user IDs remain active for periods as long as a year or more despite the fact that users do not use the system.
- Non-implementation of standard systems security practices

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**Effect:** Personnel who may not have a legitimate business need may access the system and pass unsupported or unauthorized payments to the primary accounting system.

**Recommendation:** We recommend that the Department improve systems security procedures by:

- Reviewing user access to Oracle Financials and deleting or revoking user IDs for personnel who do not need to use the system.
- Implementing the workflow module into Oracle Financials.
- Considering methods to isolate vendor/programmer access from the production system in a manner that will not cause undue delay or complexity in transaction processing.

**Management Response/Corrective Action Plan:** *The Department of Health and Human Services agrees with this finding.*

***Review user access to Oracle Financials and delete or revoke user IDS for personnel who do not need to use the system.***

*A quarterly review of user ID's will be implemented and unauthorized personnel will have their user ID's access to the various modules end dated. New user ID's access to various modules will need security level assignment and authorization.*

***Consider implementing the workflow module into Oracle Financials.***

*DHHS will be preparing an analysis of the impact of implementing the workflow module into Oracle Financial. DHHS projects the analysis to be complete during fiscal year 2009.*

***Consider methods to isolate vendor/programmer access from the production system in a manner that will not cause undue delay or complexity in transaction processing.***

*The MECMS and Oracle Financial systems are still in stages of development. Isolation of Vendor/Programmer access will be addressed when the systems become more stable.*

*Additionally, as the Department transitions to a fiscal agent to manage Medicaid claims, vendor access will be isolated.*

**Contact:** *Brian Guerrette, DHHS/OIT/DAFS, Systems Section Manager, 287-1748*

## MEDICAID CLUSTER

(28)

**Finding Title:** Noncompliance with Automatic Data Processing (ADP) review requirements

**Prior Year Finding:** 05-60

**CFDA:** 93.775, 93.777, 93.778

**CFDA Title:** Medicaid Cluster

**Federal Award:** 05-0505ME5028, 05-0605ME5028

**Federal Agency:** U.S. Department of Health and Human Services

**State Department:** Health and Human Services (DHHS)  
Administrative and Financial Services (DAFS)

**Bureau:** Office of Information Technology (OIT)

**Finding Type:** Internal control and compliance

**Compliance Area:** Special tests and provisions

**Known Questioned Cost:** None

**Likely Questioned Cost:** None

**Criteria:**

- 45 CFR §95.621; 45 CFR §95.601
- 45 CFR §95.621 requires the state agency to “establish and maintain a program for conducting periodic risk analyses...whenever significant system changes occur” and to “maintain reports of their biennial ADP (*Automatic Data Processing*) system security reviews, together with pertinent supporting documentation, for HHS on-site review.” Furthermore, the requirements apply to programs covered under 45 CFR part 95, subpart F, which includes Title I, IV-A, IV-B, IV-D, IV-E, X, XIV, XVI(AABD), XIX, or XXI of the Social Security Act and Title IV Chapter 2 of the Immigration and Nationality Act.

**Condition:** DHHS does not conduct formal security reviews of ADP systems on a biennial basis as required; and has not conducted and documented periodic risk analyses. While DHHS, supported by services provided by OIT, may have implemented many elements of a security plan as required including: (A) Physical security; (B) Equipment security; (C) Software and data security; (D) Telecommunications security; (E) Personnel security; (F) Contingency plans; (G) Emergency preparedness; and (H) Designation of an Agency ADP Security Manager; it has not formally implemented security review and risk analysis procedures and adequately documented the results.

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**Context:** DHHS is responsible for the security of all ADP projects under development, and operational systems involved in the administration of DHHS programs within the scope of 45 CFR part 95 subpart F. as follows:

<b>Social Security Act</b>	
<b>Title:</b>	
I	Grants to States for Old-Age Assistance for the Aged
IV-A	Block Grants to States for Temporary Assistance for Needy Families
IV-B	Child and Family Services
IV-D	Child Support and Establishment of Paternity
IV-E	Federal Payments for Foster Care and Adoption Assistance
X	Grants to States for Aid to the Blind
XIV	Grants to States for Aid to the Permanently and Totally Disabled
XVI(AABD)	Grants to States for Aid to the Aged, Blind or Disabled
XIX	Grants to States for Medical Assistance Programs
XXI	State Children's Health Insurance Program
<b>Immigration and Nationality Act</b>	
<b>Title:</b>	
IV Chapter 2	Refugee Assistance

Systems subject to the requirements may include, but are not limited to: Automated Client Eligibility System (ACES), Maine Claims Management System (MECMS), the State's primary accounting system (MFASIS), Welfare Information System (WELFRE), Oracle Financials, New England Child Support Enforcement System (NECSES), Maine Automated Child Welfare Information System (MACWIS), Enterprise Information System (EIS), Managed Care System (MECAPS), Long Term Assessment Tool (MECARE), Immunization Registry (ImPACT), IBM and Bull mainframe systems, database servers, as well as the network infrastructure that supports those systems.

**Cause:**

- Lack of personnel and resources
- Insufficient understanding or awareness of program requirements

**Effect:**

- Potential for inadequate safeguards to protect integrity and confidentiality of data
- Potential for unauthorized entry into operations, data storage, library and other support areas
- Potential for equipment loss or damage due to theft, sabotage, natural disaster or other threats
- Noncompliance with federally promulgated system review requirements
- Possible suspension or denial of federal financial participation for information systems or other penalties

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**Recommendation:** To ensure that the level of security over DHHS' systems is adequate and to comply with regulations, we recommend that the Department:

- Conduct the required biennial ADP system security reviews and maintain reports of results.
- Establish a comprehensive risk analysis program.
- Assess the adequacy of the protective measures and controls that are needed to meet the pertinent federal ADP security requirements and standards.
- Continue to review the adequacy of those safeguards/controls on a biennial basis.
- Make a determination of compliance with the ADP security requirements.
- Write the policy and procedures of the ADP security program.

**Management Response/Corrective Action Plan:** *The audit finding suggests that a formal security review of Automated Data Processing systems does not occur on a regular/biennial basis, and that elements of a plan have been implemented in a scattered, non-formalized or organized, fashion. We partially agree with this finding.*

*In fact, we do have areas where formal and organized reviews are performed on a regular basis. For example, we do an IRS safeguard review for NECSES and ACES every two years. This is a comprehensive undertaking, and takes into consideration OIT's Application Hosting, High Speed Printing and Data Center services. These are the same services that many of the other DHHS systems fall subject to, including MACWIS, MAPSIS, EIS, MFASIS, and WELFRE.*

*We also have a security policy that has been aligned with HIPAA requirements. A contractor was brought on board to review and adjust our policy as necessary.*

*That said, more systems need to have the same level of detailed review, and a comprehensive DHHS centric report should be compiled. In fiscal year 2008, OIT will develop a DHHS-wide report on application systems. The report will include the following components for applications:*

- A. Physical security
- B. Equipment security
- C. Software and data security, including periodic penetration testing
- D. Telecommunications security
- E. Personnel security; Contingency plans
- F. Emergency preparedness
- G. Designation of an Agency ADP Security Manager(s)

*In order to balance workload, it is envisioned that reviews will happen for half the applications in one fiscal year, the other half in the second. We will look at the feasibility of this report taking into account the DHHS IT Security policy, the IRS Safeguard Review, and SSA Review as well. The approach and plan will be developed by January 31, 2008. The schedule for implementing this plan will be included in this deliverable.*

**Contact:** Jim Lopatosky, DHHS - Information Technology Director, 287-2778

## MEDICAID CLUSTER

(29)

**Finding Title:** Individual Care Plan authorized services incomplete

**Prior Year Finding:** No

**CFDA:** 93.775, 93.777, 93.778

**CFDA Title:** Medicaid Cluster

**Federal Award:** 05-0505ME5028, 05-0605ME5028

**Federal Agency:** U.S. Department of Health and Human Services

**State Department:** Health and Human Services (DHHS)

**Bureau:** Adults with Cognitive & Physical Disability Services

**Finding Type:** Internal control and compliance

**Compliance Area:** Special tests

**Known Questioned Cost:** None

**Likely Questioned Cost:** None

**Criteria:**

- 42 CFR §440.180; §441.301
- Maine's Waiver Agreement Appendix E-2 (b)(1)
- U.S Department of Health and Human Services, Understanding Medicaid Home and Community Services: A Primer
- MaineCare Benefits Manual §21.05-1, §21.07, §21.07-1, §21.07-2

**Condition:** Individual Care Plans (ICP) did not consistently document authorized services; authorized units did not always represent reasonable estimates of services considered necessary. Many Plans indicated full-time residential placements, but did not specify the amounts/units of service authorized or the frequency of service. Only a few checklists indicated 365 days of service and only a few units could be tied back to authorization in the treatment plans.

- 28 of 60 (47%) Individual Care Plan narratives did not identify the amount and/or frequency of units of service authorized
- 24 of 60 (40%) Individual Care Plans amounts or frequencies of service did not agree to the amounts reflected on Individual Checklists, which serve as the means of authorizing payment in the Claims payment system

**Context:** Federal regulations require that all Waiver services be furnished pursuant to a written service plan that is developed for each waiver participant.

**Cause:** DHHS considers the checklist a part of the Individual Care Plan and that it is not necessary to also include units in the narrative and then abstract them to the checklist. As DHHS allocates the provider's costs to whatever units of service are indicated, the units really serve more as a billing mechanism rather than a true measure of service delivered.

## MEDICAID CLUSTER

**Effect:** Individual Care Plans do not consistently document the amount and frequency of service. Checklist units and rates, which appear to represent the apparent costs to treat individual clients, are in large part a mechanism for the Program to cover total provider costs; the units and rates are not a reliable means to compare or contrast the costs of providing services to specific clients, especially as they are changed as needed to adjust client specific provider payments to cover provider costs.

**Recommendation:** We recommend that the Department:

- Provide guidance to its staff regarding consistent preparation of Individual Care Plans.
- Establish meaningful units of service to be provided.
- Ensure that the ICP narrative and checklists unit agree .

**Management Response/Corrective Action Plan:** *The Department of Health and Human Services agrees with the recommendations of this finding, and believes it is in compliance.*

*Each waiver participant has a personal plan developed annually. The Department does provide guidance and training to staff regarding consistent preparation of Person Centered Planning. The Department is willing to provide copies of the training materials on personal planning.*

*The disagreement in the finding is around the development of the checklist which is used to establish the units of authorized services.*

*The checklist is a distinct separate component of individual plans; its primary purpose is to identify the authorized units and cost per unit of each waiver service. Most often this is developed after the planning meeting has occurred based on the identification of the support needs of the individual. Hence, the checklist is a summary of the services defined in the original planning meeting. The Department is improving the checklist by adding improved descriptions of each service to ensure that staff is appropriately documenting necessary services.*

*The Department has a review process for a sample number of person centered plans in order to verify that the narrative is inclusive of all services needed by the individual.*

*This fall the Department will be moving to a standardized and published rate system which will remove any appearance that rates having been arbitrarily set.*

**Contact:** Jane Gallivan, DHHS - Program Systems Director, 287-4212

**Auditor's Conclusion:** Our examination results indicated noncompliance.

The finding remains as stated.

## MEDICAID CLUSTER

(30)

**Finding Title:** Inadequate surveillance and utilization review of Medicaid prescription drugs and supplies

**Prior Year Finding:** No

**CFDA:** 93.775, 93.777, 93.778, 93.767

**CFDA Title:** Medicaid Cluster

State Children's Insurance Program (SCHIP)

**Federal Award:** 05-0505ME5028, 05-0605ME5028; 05-0405ME5021; 05-0505ME5021

**Federal Agency:** U.S. Department of Health and Human Services

**State Department:** Health and Human Services (DHHS)

**Bureau:** Office of MaineCare Services

**Finding Type:** Internal Control and compliance

**Compliance Area:** Special tests and provisions

**Known Questioned Cost:** \$11

This is the federal portion of one detected overpayment in a sample of 40 Medicaid prescription payments. A pharmacy dispensed a prescription for double the amount prescribed by the physician.

**Likely Questioned Cost:** \$329,009

The likely questioned cost amount was computed by applying the error rate of .22% to the population of federal Medicaid expenditures for prescription drugs (\$156,963,014).

**Criteria:** 42 CFR §456.1(b)(8)

42 CFR §456.709

42 CFR §456.716

MaineCare Benefits Manual, Chapter II §80.04

**Condition:** DHHS does not have an adequate drug use review program as required by 42 CFR §456.1(b)(8). The drug use review program does not include the standardized retrospective examination of claims data required by 42 CFR §456.709. Section 709 requires that actions be taken to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care by pharmacists; and DHHS does not provide the Drug Utilization Review Board with ongoing periodic claims data to identify these patterns. Because of the absence of other testing, we extended our examination by sampling 40 Medicaid prescription transactions; we detected 13 pharmacy dispensing exceptions as follows:

- Four instances when the prescription was not dated and no follow-up with the physician was documented (including one instance involving a controlled substance)
- One instance when the pharmacy dispensed and charged double the prescribed amount resulting in a federal questioned cost
- One instance when the pharmacy could not locate the prescription
- One instance when the prescription was not signed by the physician and no follow-up with the physician was documented



## MEDICAID CLUSTER

- One instance when it was the national pharmacy's policy not to obtain a signature acknowledgement that the prescription was picked-up
- One instance when an out-of-state pharmacy claimed they could not provide a copy of the signature acknowledgement that the prescription was picked up due to a limitation imposed by their electronic system
- Four other instances relating to unclear quantities, a missing drug description, an unclear dosage; combined with no documented follow-up with the physician

**Context:** The Medicaid and SCHIP programs expended approximately \$250 million for prescription drugs in fiscal year 2006. The MaineCare Benefits Manual, Chapter II §80.04, states that the goal of the Drug Utilization Review Committee is to assure that prescriptions are appropriate, medically necessary, and not likely to result in adverse results.

**Cause:** Management's attention was directed to other areas; after the year of audit the pharmacy unit hired an analyst.

**Effect:**

- Pattern analysis using predetermined standards cannot be conducted as required by 42 CFR §709
- Fraud, abuse, gross overuse, or inappropriate or medically unnecessary care may not be detected on a timely basis

**Recommendation:** We recommend that the Department have an adequate drug use review program, and provide the Drug Utilization Review Board with ongoing periodic drug claims data as required by federal and State law.

**Management Response/Corrective Action Plan:** *The Department of Health and Human Services agrees with this finding.*

*The Department of Health and Human Services will provide the Drug Utilization Review Board with a standardized quarterly report ("Claims Trending Report") tracking defined pharmacy claim trends along with any recommendations for remedial action.*

*The Program Integrity Unit will dedicate a position to focus on pharmacy reviews; it is anticipated that the position will be filled in December 2007. The position will be reviewing and addressing the conditions listed above. A quarterly report of the site findings will be submitted to the Manager of the Pharmacy Unit. The Manager will report the Dispensing Practices of Pharmacies to the Drug Utilization Review Board along with the Quarterly Claims Trending Report noted above.*

*An assembled set of report criteria will be presented to the DUR at their December 2007 meeting. The first report will be due at the February 2008 quarterly meeting.*

**Contact:** Carol Bean, DHHS - Comprehensive Health Planner II, 287-3941

## MULTIPLE PROGRAMS

(31)

**Finding Title:** Inadequate internal controls and noncompliance with allowable costs requirements

**Prior Year Finding:** 05-35

**CFDA:** 10.551, 10.561, 93.558, 93.563, 93.658, 93.659, 93.767, 93.775, 93.777, 93.778

**CFDA Title:** Food Stamp Cluster

Temporary Assistance for Needy Families

Child Support Enforcement

Foster Care – Title IV-E

Adoption Assistance

State Children’s Insurance Program

Medicaid Cluster

**Federal Award:** 4ME400401, METANF06, 0604ME4004,  
0601ME1401, 0601ME1407, 05-0405ME5021,  
0505ME5R21, 05-0505ME5028, 05-0605ME5028

**Federal Agency:** U.S. Department of Agriculture  
U.S. Department of Health and Human Services

**State Department:** Administrative and Financial Services (DAFS)

**Bureau:** Health and Human Services Service Center

**Finding Type:** Internal control and compliance

**Compliance Area:** Allowable costs/Cost principles

**Known Questioned Cost:** Undeterminable

**Likely Questioned Cost:** Undeterminable

**Criteria:** General Administration – Cost Allocation Plans (45 CFR §95.507, §95.519)

**Condition:** The Department did not implement adequate controls to ensure accurate financial reporting and compliance with the prescribed methods to allocate costs. The Department of Health and Human Services has an approved cost allocation plan that no longer reflects the current operation of the Department. The errors include:

- Reported allocated costs were not based on final allocated costs
- Incorrect amounts were entered on cost allocation schedules
- Factor rates were not updated and could not be adequately supported

**Context:** This is a systemic problem.

**Cause:**

- Staff turnover
- Changes to cost allocation schedules for the Medicaid program were not communicated adequately to allow for accurate reporting of allocated costs

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- The methodology for accumulating and allocating costs is not adequately documented

### **Effect:**

- Inaccurate financial reports
- Unallowable costs claimed
- Potential future questioned costs

**Recommendation:** We recommend that the Department continue in its efforts to develop and implement a revised cost allocation plan.

**Management Response/Corrective Action Plan:** *The Department of Health and Human Services and the Department of Administrative and Financial Services agree with this finding. While the causes cited were addressed in fiscal year 2006, continued staff turnover prevented the Department's ability to efficiently adjust and re-submit federal financial reports within that time frame.*

*A Financial Analyst is assigned the task of managing the cost allocation plan. A Management Analyst processes the plan quarterly and posts bi-weekly funding and quarterly reconciliation journals, and these journals are reviewed and approved by the Financial Analyst. Prior year cost allocation schedule corrections were calculated in fiscal year 2006; staffing limitations and workloads of existing employees, however, caused these corrections to occur later than expected; this also caused delay to revisions to the federal reports.*

*A new Department-wide Public Assistance Cost Allocation Plan (PACAP) was submitted to the federal Division of Cost Allocation (DCA) in New York in December 2005 and a revision was submitted in March 2006. These submissions were distributed by DCA to the cognizant agencies overseeing Maine DHHS activities. Preliminary inquiries regarding the plan were received by DCA and responded to in March 2007.*

**Contact:** Mark Toulouse, DAFS, DHHS Service Center - Deputy Director, 287-1869

(32)

**Finding Title:** Inadequate internal controls and noncompliance with federal cost principles

**Prior Year Finding:** No

**CFDA:** 10.551, 10.561, 93.558, 93.563, 93.575, 93.596, 93.658, 93.659, 93.667, 93.767, 93.775, 93.777, 93.778

**CFDA Title:** Food Stamp Cluster

Temporary Assistance for Needy Families

Child Support Enforcement

Child Care Cluster

Foster Care – Title IV-E

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Adoption Assistance  
Social Services Block Grant  
State Children's Insurance Program  
Medicaid Cluster

**Federal Award:** 4ME400401, METANF06, 0604ME4004,  
G0501MECCDF, G0601MECCDF, 0601ME1401,  
0601ME1407, MESOSR05, MESOSR06, 05-0405ME5021,  
0505ME5R21, 05-0505ME5028, 05-0605ME5028

**Federal Agency:** U.S. Department of Agriculture  
U.S. Department of Health and Human Services

**State Department:** Administrative and Financial Services (DAFS)

**Bureau:** Health and Human Services Service Center

**Finding Type:** Internal control and compliance

**Compliance Area:** Allowable costs/Cost principles

**Known Questioned Cost:** \$2,129,301 (\$1,249,000 SSBG; \$880,301 CCDF)

**Likely Questioned Cost:** Undeterminable

**Criteria:** Cost Principles for State, Local, and Indian Tribal Governments (OMB Circular A-87)

**Condition:** The Department did not have adequate procedures in place to ensure that the proper amounts of allocated costs were journaled to the various federal programs. The errors include:

- Several programs paid excessive regional operations costs due to insufficient funding in other programs
- Two programs paid excessive legal services costs (included in the questioned costs)
- One program was not charged its share of Office of Integrated Access and Support costs
- Total costs to be allocated to the various federal programs were calculated inaccurately

**Context:** This is a systemic problem. Throughout the fiscal year, three Bureaus of the Department of Health and Human Services (DHHS) did not pay for their share of regional operations costs which totaled \$6.7 million. As a result, the remaining DHHS programs paid \$5.6 million in excessive regional operations costs, causing some programs to overdraw from their respective grants. Although this \$5.6 million was returned to the program accounts in fiscal year 2007, the three DHHS Bureaus have not yet paid for their share of fiscal year 2006 costs.

For fiscal year 2006, Social Services Block Grant (SSBG) paid for and reported \$1.2 million in excess legal services costs. The Child Care Development Fund (CCDF) paid

## MULTIPLE PROGRAMS

for and reported \$1.3 million in excess legal services costs; however, since DHHS returned \$392,800 to CCDF in September 2006, we will only question the remaining \$880,301. We also note that CCDF requested and received an additional State appropriation of \$3 million to cover program costs for which federal funds were not available.

**Cause:**

- Inadequate accounting procedures
- Insufficient funds

**Effect:**

- Current and potential future questioned costs
- Disproportionate share of allocated costs charged to federal programs

**Recommendation:** We recommend that the Department implement accounting procedures to ensure that the State's accounting system adequately reflects the proper allocation of pooled costs.

**Management Response/Corrective Action Plan:** *The Department of Administrative and Financial Services, DHHS Service Center agrees with this finding.*

*Funds were received in the fiscal year 2007 supplemental budget to correctly post regional operations costs for which federal funds were not available. As fiscal year 2007 progressed, however, the regional operations account, which is funded by bi-weekly journals based on historical quarters, was able to partially correct the allocations via JV10A8107DW0006 in March 2007. The final reconciliation for fiscal year 2007 was posted via ABSJ10A8107DW0003 in August 2007. The two journals transferred regional operations general funds (the latter journal from the fiscal year 2007 supplemental appropriation) on behalf of the three bureaus in question. Similarly, journals were posted in fiscal year 2007 correcting the fiscal year 2006 underpayment using fiscal year 2007 supplemental funds. It is the Department's belief that, through these journal transfers, the bureaus in question have paid their respective portions of fiscal year 2006 and fiscal year 2007 costs. In the new department cost allocation plan, effective July 1, 2007, a reconciliation process is in place whereby those costs assigned to federal programs that cannot be absorbed by those programs due to federal fund participation (FFP) rates, will be transferred to the allocated account's general fund within a unit referring to the federal program assigned the cost. The first such reconciliation will be processed after quarter ending September 30, 2007.*

*We agree that Attorney General fees charged were incorrectly posted. A correction returning funds to the child care development block grant from foster care and adoption assistance accounts was posted via JV 10A 8107KK09018 on 9/27/06, covering quarters ending 12/31/05, 3/31/06, and 6/30/06. The Department feels it can perform analysis and post the remaining corrections before 10/31/07, the due date for the next quarterly IV-E report.*

## MULTIPLE PROGRAMS

*Contact: Mark Toulouse, DAFS, DHHS Service Center - Deputy Director, 287-1869*

(33)

**Finding Title:** Inadequate internal controls and noncompliance with federal matching requirements

**Prior Year Finding:** No

**CFDA:** 10.551, 10.561, 93.563, 93.658,  
93.659, 93.775, 93.777, 93.778

**CFDA Title:** Food Stamp Cluster  
Child Support Enforcement  
Foster Care – Title IV-E  
Adoption Assistance  
Medicaid Cluster

**Federal Award:** 4ME400401, 0604ME4004, 0601ME1401,  
0601ME1407, 05-0505ME5028, 05-0605ME5028

**Federal Agency:** U.S. Department of Agriculture  
U.S. Department of Health and Human Services

**State Department:** Administrative and Financial Services (DAFS)

**Bureau:** Health and Human Services Service Center

**Finding Type:** Internal control and compliance

**Compliance Area:** Matching, level of effort, earmarking

**Known Questioned Cost:** Undeterminable

**Likely Questioned Cost:** Undeterminable

**Criteria:** Uniform Administrative Requirements for Grants and Cooperative Agreements to State, Local, and Tribal Governments (45 CFR §92.20, §92.24)

**Condition:** The Department did not have adequate controls to ensure that federal matching requirements were met with respect to allocated costs. We tested two allocation schedules, one to allocate legal services costs and another to allocate Office of Integrated Access and Support costs. We were unable to find State funded expenditures at the level necessary to meet the various matching requirements for the federal programs participating in these cost pools.

**Context:** This is a systemic problem. For the two allocation schedules tested, State paid expenditures were deficient by \$3.1 million to meet the various federal matching requirements. Federal funds were most likely drawn to cover some of the State's share of these allocated costs. However, due to the complexity with the accounting associated with the Department of Health and Human Services' cost allocation plan, we were unable to calculate unmet State match.

## MULTIPLE PROGRAMS

**Cause:** The Department assumes that the General fund appropriation received for the allocated cost pools is sufficient to help meet the State's matching requirements. However, no reconciliation is performed to ensure that this assumption is correct.

**Effect:**

- Possible noncompliance with federal matching requirements
- Potential questioned costs

**Recommendation:** We recommend that the Department implement procedures to ensure federal matching requirements are met with respect to allocated costs.

**Management Response/Corrective Action Plan:** *The Department of Health and Human Services and the Department of Administrative and Financial Services agree with this finding.*

*While the quarterly reconciliation process assured that federal programs were not overcharged, match calculations could not easily be determined due to the various funds used in the Department's allocated accounts. This issue has been addressed in the Department's new cost allocation plan, submitted to the Division of Cost Allocation (DCA) in December 2005 with a revision submitted in March 2006. In the new plan's reconciliation process, expenditures assigned to a federal program but not chargeable due to the program's federal participation rate will be transferred to the allocated account's general fund within a unit (formerly report org) identifying the program. After a particular quarter's reconciliation process, queries can be executed that will identify both the amount of allocated costs posted to a particular program, as well as those costs retained in the allocated general fund account on behalf of that particular program. This new reconciliation process will begin with fiscal year 2008 allocated costs. The first reconciliation will take place in October 2007.*

**Contact:** Mark Toulouse, DAFS, DHHS Service Center - Deputy Director, 287-1869

(34)

**Finding Title:** Inadequate internal controls and noncompliance with SEFA reporting requirements

**Prior Year Finding:** No

**CFDA:** 93.268, 93.558, 93.563, 93.575, 93.596, 93.659, 93.775, 93.777, 93.778

**CFDA Title:** Immunization Grants

Temporary Assistance for Needy Families

Child Support Enforcement

Child Care Cluster

Adoption Assistance

Medicaid Cluster

## MULTIPLE PROGRAMS

**Federal Award:** H23/CCH122558, METANF06, 0604ME4004, G-0501MECCDF, G-0601MECCDF, G-0601ME1407, 05-0505ME5028, 05-0605ME5028

**Federal Agency:** U.S. Department of Health and Human Services

**State Department:** Administrative and Financial Services (DAFS)

**Bureau:** Health and Human Services Service Center, Office of the State Controller

**Finding Type:** Internal control and compliance

**Compliance Area:** N/A

**Known Questioned Cost:** N/A

**Likely Questioned Cost:** N/A

**Criteria:** Audits of States, Local Governments, and Nonprofit Organizations – Schedule of Expenditures of Federal Awards (OMB Circular A-133 §310(b))

**Condition:** The Department did not have adequate internal controls in place to ensure that it correctly reported expenditures for the Schedule of Expenditures of Federal Awards (SEFA) for six Department of Health and Human Services programs.

**Context:** Initial SEFA expenditures were understated as follows:

- Temporary Assistance for Needy Families - \$6.3 million
- Child Support Enforcement - \$1.1 million
- Child Care Cluster - \$2.9 million
- Adoption Assistance - \$11.6 million
- Medicaid Cluster - \$42 million

Additionally, while the amount reported on the draft SEFA for the Immunization Program was essentially correct, the information used to compile the SEFA included two significant off-setting errors.

**Cause:**

- Insufficient understanding of how to appropriately compile SEFA expenditures
- Inadequate oversight
- Unrelated financial statement adjustments were incorrectly included in draft SEFA amounts for certain programs
- The draft SEFA was not updated after revised expenditure reports were submitted to the federal government
- Vaccines that were distributed and purchased with State funds were included in the draft SEFA

**Effect:** Incorrect SEFA

**Recommendation:** We recommend that the Department develop procedures to ensure that federal expenditures are correctly reported on the SEFA.



## MULTIPLE PROGRAMS

**Management Response/Corrective Action Plan:** *The Department of Health and Human Services and the Department of Administrative and Financial Services agree with this finding.*

*The SEFA (Schedule of Expenditures of Federal Awards ) report for fiscal year 2006 was a learning experience for many completing the SEFA for the first time; of the eight individuals working on the SEFA five were new to the process. After going through the process and reviewing the audit findings there is a much better understanding of SEFA reporting.*

*Beginning with fiscal year 2007 SEFA all program accounting staff have been given the total MFASIS (Maine Financial & Administrative Statewide Information System) expenditures by program which ties to the total agency expenditure report sent out by the Office of the State Controller. Accounting staff have been instructed to balance the program Financial Status Reports to this figure and indicate reasons for variances. This procedure should assure a more accurate SEFA reporting. Notification will be sent to all accounting staff to inform the Financial Analyst responsible for SEFA reporting of any revisions to program Financial Status Reports.*

**Contact:** *Donna Wheeler, DAFS, DHHS Service Center - Financial Analyst, 287-1860*

*OSC has procedures in place to address agency filing issues from a number of standpoints. Our annual SEFA reporting instruction package includes detailed instructions for completing the SEFA, information on new and deleted programs and program name changes, and a reconciliation template that automatically removes transfers and donated items from totals reported in MFASIS, which includes definitions of transfers and pass-thrus in order to avoid confusion. Meetings are held with agency accountants needing assistance with preparing the SEFA, and we stress the importance of reconciling all programs back to MFASIS totals and reviewing transfers and pass-through amounts with other agencies to agency management. For fiscal year 2007 reporting, we plan on holding a meeting with program accountants and the person responsible for preparing the SEFA in order to best clarify what expenses ought to be reported as expenditures. We have also updated the template with 3 cautions and pop-up comments when pass-thrus or transfers are identified.*

**Contact:** *April Newman, DAFS - OSC, Financial Management Coordinator, 626-8436*

## MULTIPLE PROGRAMS

(35)

**Finding Title:** Inadequate controls over federal cash management requirements

**Prior Year Finding:** 05-36

**CFDA:** 93.558, 93.575, 93.778, 93.596, 93.775, 93.777

**CFDA Title:** Temporary Assistance for Needy Families

Child Care Cluster

、 Medicaid Cluster

**Federal Award:** METANF06, G-0401MECCDF, G-0501MECCDF, 05-0505ME5028, 05-0605ME5028

**Federal Agency:** U.S. Department of Health and Human Services

**State Department:** Administrative and Financial Services (DAFS)

**Bureau:** Health and Human Services Service Center

**Finding Type:** Internal control and compliance

**Compliance Area:** Cash management

**Known Questioned Cost:** None

**Likely Questioned Cost:** None

**Criteria:** Rules and Procedures for Efficient Federal - State Funds Transfers - Rules Applicable to Federal Assistance Programs Included in a Treasury-State Agreement (31 CFR §205 Subpart A)

**Condition:** The Department did not have adequate internal controls in place to ensure compliance with the terms of the 2006 Treasury-State Agreement on cash management. Draws of federal cash were both earlier and later than the Agreement allowed. Additionally, the Department could not provide adequate supporting documentation for certain draws.

**Context:** This is a systemic problem.

**Cause:**

- Timing of draws is not based on disbursement dates
- Lack of adequate documentation to support amounts being drawn
- Amounts drawn include adjustments for overall cash position which do not relate to specific program expenditures

**Effect:**

- Insufficient cash for the payment of disbursements
- Excess federal cash on hand could result in an interest liability due the federal government

**Recommendation:** We recommend that the Department:

## MULTIPLE PROGRAMS

- Improve grant accountability so that program managers and accountants are able to comply with the terms to the Treasury-State Agreement.
- Consistently maintain adequate documentation to support draws of federal cash.

**Management Response/Corrective Action Plan:** *The Department of Health and Human Services and the Department of Administrative and Financial Services agree with this finding.*

*As of July 2007, DHHS Service Center has assigned a financial analyst to oversee all cash management for the Department. This person has met with the Treasurer's Office CMIA (Cash Management Improvement Act ) administrator and has started to implement procedures to limit draws to comply with federal cash management rules.*

**Contact:** Charles Woodman, DHHS Service Center - Deputy Director, 287-2572

(36)

**Finding Title:** Inadequate controls over the administration of federal funds

**Prior Year Finding:** 05-21, 05-27, 05-35, 05-36

**CFDA:** Various

**CFDA Title:** Various

**Federal Award:** Various

**Federal Agency:** U.S. Department of Health and Human Services  
U.S. Department of Agriculture

**State Department:** Administrative and Financial Services

**Bureau:** Health and Human Services Service Center

**Finding Type:** Internal control

**Compliance Area:** Allowable costs/Cost principles, Cash management, Reporting

**Known Questioned Cost:** None

**Likely Questioned Cost:** None

**Criteria:** Uniform Administrative Requirements for Grants and Cooperative Agreements to State, Local, and Tribal Governments – Standards for Financial Management Systems (45 CFR §92.20)

**Conditions:** The Department does not consistently utilize separate accounts within the State's accounting system for each federal program. For some federal programs, "reporting organizations" are used for individual programs but are combined into a single "appropriation organization," which controls the cash for multiple programs. The Department is not always able to provide a complete and accurate list of the accounts established and used for each program.

## MULTIPLE PROGRAMS

The State's accounting records do not accurately reflect the sources and uses of funds. Transactions are not always posted or transferred to the relevant accounts. This is particularly true for costs related to accounts within the Department's cost allocation plan. Those costs are significant because they include regional office costs and other costs that benefit multiple programs. This process complicates the administration of federal funds.

The Department "self-funds" some programs through a method they refer to as "earned revenue". This "earned revenue" is the result of federally qualified expenditures having been paid for with State funds. When the Department subsequently receives federal reimbursement, the State's General Fund is not refunded. Instead, these federal reimbursements are often transferred to Other Special Revenue Fund accounts and used to "self-fund" other Department programs. The "earned revenue" amounts transferred were sometimes estimates based on budgeted amounts that may not have agreed with actual qualified expenditures. In addition we noted that certain calculations to determine the "earned revenue" contained formula errors. This "self-funding" approach also makes tracing the sources and uses of funds difficult or, if proper documentation is not maintained, impossible. Additionally, we could not determine if the Department actually had legislative authority to retain the "earned revenue" rather than reimburse the General Fund. The Title IV-E Foster Care and Adoption Assistance Programs are examples of programs that used the "earned revenue" approach.

**Context:** This is a systemic problem.

**Cause:**

- Incomplete written policies and procedures
- Inadequate accounting structure
- Overly complex accounting

**Effect:**

- Difficulty identifying sources and uses of funds
- Insufficient supporting documentation
- Noncompliance with federal regulations (e.g. cash management, reporting, allowable cost/cost principles, etc.)

**Recommendation:** We recommend that the Department:

- Establish and maintain a chart of accounts
- Document all procedures in writing
- Record all activity relating to specific programs into distinct accounts
- Consistently review and reconcile account activity
- Obtain legislative authority for use of "earned revenue" as a mechanism for self-funding or discontinue this process

## MULTIPLE PROGRAMS

**Management Response/Corrective Action Plan:** *The Department of Administrative and Financial Services, DHHS Service Center agrees with the finding and has implemented many of the recommendations.*

*Legislative authority for the use of “earned revenue” was granted in PL 2007, C.1, section V-1.*

*The DHHS Service Center established the chart of accounts which was incorporated into the DHHS Cost allocation submission.*

*The DHHS Service Center disagrees with the Department of Audit recommendation to use separate accounts within the State’s accounting system for each federal program. The effort to separately budget, maintain and report on over one hundred and fifty active grants is not possible given the current level of staffing.*

**Contact:** Charles Woodman, DAFS, DHHS Service Center - Deputy Director, 287-2572

(37)

**Finding Title:** Inadequate support for the Federal Cash Transaction Report (PSC-272)

**Prior Year Finding:** 05-32

**CFDA:** 93.041, 93.110, 93.234, 93.283, 93.556, 93.558, 93.563, 93.566, 93.596, 93.600, 93.645, 93.658, 93.659, 93.671, 93.674, 93.775, 93.777, 93.778, 93.917

**CFDA Title:** Title VII Elder Abuse Prevention

Maternal and Child Health

Traumatic Brain Injury

Investigations and Technical Assistance

Promoting Safe and Stable Families

Temporary Assistance for Needy Families

Child Support Enforcement

Refugee Assistance

Mandatory and Matching Funds of Child Care Development Fund

Head Start

Child Welfare Services

Foster Care Title IV-E

Adoption Assistance

Family Violence Prevention

Chafee Foster Care Independence

Medicaid Cluster

HIV Care

## MULTIPLE PROGRAMS

**Federal Award:** 06AAMET7SP, H74MC00003-A0, P05MC00061-A0, OCCU122825, OCCU122057, 0501ME00FP, 0601ME00FP, 0501METANF, 0404ME4004, 9804ME4004, 9704ME4004, 9904ME4004, 0604ME4004, 0204ME4004, 0104ME4004, 05AAME1100, 06AAME1100, 06AAME1110, 0601MECCDF, 0601ME1400, 0401ME1401, 0501ME1407, 0401MEFVPS, 0601ME1420, 0501ME1420, 01CD000805, 0605ME5048, 0405ME5028, 0505ME5028, 0605ME5028, HAX070023O

**Federal Agency:** U.S. Department of Health and Human Services

**State Department:** Administrative and Financial Services

**Bureau:** Health and Human Services Service Center

**Finding Type:** Internal control and compliance

**Compliance Area:** Reporting (PSC-272)

**Known Questioned Cost:** None

**Likely Questioned Cost:** None

**Criteria:** Uniform Administrative Requirements for Grants and Cooperative Agreements to States, Local and Tribal Governments – Standards for Financial Management Systems (45 CFR §92.20)

**Condition:** The Department did not have adequate procedures to ensure that the Federal Cash Transaction reports (PSC-272) were properly supported. As a result, the Department could not provide support for reported expenditures for thirteen of twenty-one programs drawn against letter of credit Y180P and four of fifty programs drawn against letter of credit 4578G.

**Context:** We reviewed reports for the quarters ending September 30, 2005 and June 30, 2006. Issues were found in both quarters. In certain instances, expenditures were based on estimates; in other instances, supporting documentation could not be provided for the reported amounts.

**Cause:**

- Supporting documentation was not retained
- Estimates were used to report expenditures

**Effect:** Expenditures reported were not properly supported.

**Recommendation:** We recommend that the Department maintain and provide adequate support for the PSC-272 reports. We further recommend that the Department report actual expenditures and not estimates.

## MULTIPLE PROGRAMS

**Management Response/Corrective Action Plan:** *The Department of Health and Human Services and the Department of Administrative and Financial Services agree with this finding.*

*The Health and Human Services Service Center will review the eleven out of seventy-one programs that were deemed to have inadequate documentation. On all new grant awards received since FY 05, actual expenditures are reported. It is the Department's policy to retain adequate documentation supporting the amounts reported on the PSC 272 report. We will take immediate action to ensure staff members are aware of the policy and provide ongoing monitoring to ensure proper documentation is being provided and retained.*

**Contact:** *Liz Hanley, Director, DAFS, DHHS Service Center, 287-1861*

(38)

**Finding Title:** Excess working capital reserves

**Prior Year Finding:** 05-34

**CFDA:** Various

**CFDA Title:** Various

**Federal Award:** Various

**Federal Agency:** U.S. Department of Health and Human Services

**State Department:** Administrative and Financial Services (DAFS)

**Bureau:** General Government Service Center

**Finding Type:** Internal control and compliance

**Compliance Area:** Allowable costs/Cost principles

**Known Questioned Cost:** \$9.4 million Retiree Health Insurance Fund; \$4.8 million Employee Health Insurance Fund; \$1.6 million Office of Information Technology Fund. Questioned costs were calculated by multiplying the excess reserves by the percentages paid by federal programs by the individual fund.

**Likely Questioned Cost:** \$15.8 million

**Criteria:** Cost Principles for State, Local and Indian Tribal Governments (OMB Circular A-87 Attachment C §G (2))

**Condition:** The Department did not comply with federal working capital reserve requirements. The Retiree Health Insurance Fund, the Employee Health Insurance Fund, and the Office of Information Technology Fund had excess working capital reserves of \$53.7, \$27.5, and \$5.9 million respectively, for fiscal year 2006. These amounts were included in the DAFS cost allocation plan submitted to the U.S. Department of Health

## MULTIPLE PROGRAMS

and Human Services in December of 2006. All amounts exceeded the 60 days of working capital allowed to be reserved in accordance with Circular A-87.

**Context:** The amount, if any, of excess working capital reserves is determined on an annual basis by DAFS. Although rates are periodically adjusted, rates charged were higher than needed to offset expenditures

**Cause:** Management decisions; Lack of history of incurred but unreported employee health claims

**Effect:** Current and potential future questioned costs

**Recommendation:** We recommend that DAFS adjust billing rates to ensure compliance with federal working capital reserve requirements.

**Management's Response/Corrective Action Plan:** *We agree that \$9.4 million Retiree Health Insurance Fund, \$4.8 million Employee Health Insurance Fund, and \$1.6 million Office of Information Technology are reasonable estimates of the federal share of reported excess retained earnings at June 30, 2006.*

### **Retiree Health Insurance Fund:**

*Prior to fiscal year 2005, the State had been in the process of changing funding of retiree health care benefits from a pay-as-you-go basis to an actuarial funding method. Due to budgetary constraints and difficulties accumulating sufficient resources to fund retiree health care benefits on an actuarial basis, PL 2003, Chapter 673 authorized the State to manage the retiree health insurance fund on a cost-reimbursement basis beginning June 30, 2005.*

*During fiscal year 2006, the State Controller and the Commissioner of Administrative and Financial Services took action to conduct research to determine the best course of action for the State and the current and retired employees of the State with regards to implementation of GASBS 45, Accounting and Financial Reporting by Employers for Post-employment Benefits Other Than Pensions. The State must implement GASB 45 in fiscal year 2008. An actuarial consultant was hired to calculate an appropriate valuation of the unfunded liability in-light of the plan's assets and assist in developing an explanation of the process put into place to educate the Administration, Legislature, and interested public about GASBS 45 and the need to address the liability that had accrued over the years that the fund was managed on a pay-as-you-go basis. In light of these circumstances, management decided not to take any action to return the fiscal year 2006 excess reserve balances calculated on a pay-as-you-go basis as it became clear that it was in the best interest of the State to revert back to funding the liability on an actuarial basis.*

*The actuaries have finished their initial valuation and have recommended an amortization and funding plan consistent with GASBS 45. Legislation has been enacted in PL 2007, Chapter 240, Part RRR to establish a trust for OPEB and to fund the Retiree*



## MULTIPLE PROGRAMS

*Health Program on an actuarial basis using the current plan's assets to make an initial deposit.*

### **Employee Health Insurance Fund:**

*The State became self insured for employee and retiree health coverage on July 1, 2003. An independent contractor provides claims administration services. The State pays the contractor a monthly premium fee based upon a rate that is determined with the assistance of an actuarial consultant. At the end of the year, premium payments are compared to actual claim payments and the outstanding balance owed or due is settled with the contractor. As this is a new self insurance program for the State, determining an appropriate rate based upon prior claims history in order to build adequate reserves for incurred but unreported claims is a challenge. The Department is currently reviewing the activity in the Employee Health Insurance Fund in order to determine the cause of the apparent excess reserve and whether funds should be returned to the supporting agencies.*

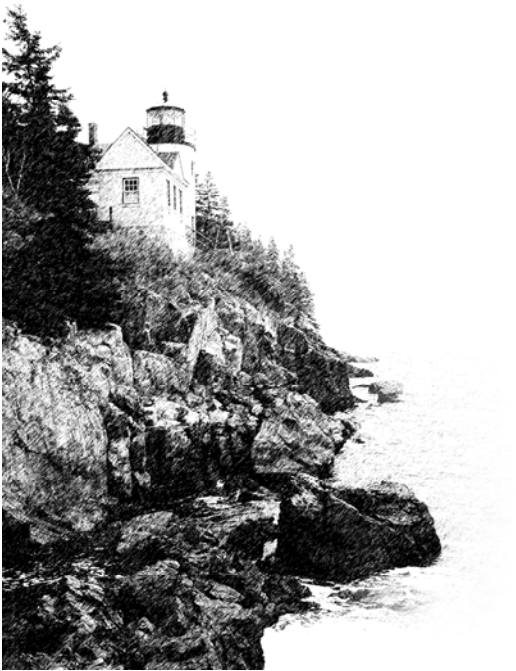
*The excess reserve balances noted in the finding are based upon OMB A-87, which allows for a working capital reserve of 2 months. Title 5, subsection 285, paragraph 9 establishes restrictions for self-insured programs including the requirement to maintain 2 ½ months of premium equivalent in reserves. The Department plans to contact the federal government to request an increase in the working capital reserve to allow for 2 ½ months of reserves to comply with Title 5.*

### **Office of Information Technology:**

*The Cost Allocation Plan excess retained earnings were \$5.9million at 6-30-06 with the federal share calculated as \$1.6million. The excess retained earnings were calculated based upon allowing a reserve for the cost of 60 days of operations, per OMB Circular A-87. However, A-87 says a working capital reserve exceeding 60 days may be approved in exceptional cases. In February 2007 the Office of Information Technology submitted a written request to the federal DHHS Division of Cost Allocation requesting a 120 day operating allowance through June 30, 2008. This letter was written in response to a Division of Cost Allocation request for resolution of fiscal year 2005 questioned costs.*

*The February 2007 letter to the federal DHHS Division of Cost Allocation outlined the many steps that OIT has taken to reduce and control retained earnings growth, including rebates to State agencies and several rate reductions. A radical reorganization of state-wide technology services in fiscal years 2006 and 2007 merged all technology services in to one Office of Information Technology. The restructuring will generate higher levels of expenses, resulting in a much larger 60 day allowance in future fiscal years.*

*We are awaiting the Cost Allocation Office's determination on our appeal for a higher retained earnings allowance that will be sufficiently high to resolve the questioned costs.*



## Medicaid Audit Team FY 2006

### Staff:

**Carol A. Lehto CPA, CIA**  
Deputy, Single Audit – Manager

### Program Areas Tested:

Interim Payments  
HCBS Waiver  
Service Provider Tax  
HIPAA Compliance  
USM -Muskie Co-Operative Agreements  
Policy review - Filing deadlines  
Contracts - Sole Source, MECMS  
DHHS Purchased Services Division

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**Robert J. Rocheleau**  
Senior Auditor - Co-lead

SEFA  
Hospital Payments/Cost Settlements  
Federal Financial Reporting  
Provider Audits  
Financial Statement testing, Actuarial and all other accruals  
Analytical Review - Variance testing  
Special Tests - Provider eligibility  
Provider health & safety standards  
  
Medicaid State Plan  
MECMS change orders  
SCHIP: Matching, Reporting, MOE, Earmarking  
Allowance for Bad Debts

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**Pola Buckley CPA, CISA**  
Principal Auditor, Co-lead

Provider Fraud - Program Integrity Unit/SURS  
Pink and green - Claims adjustment sheets  
Cost principles, expenditure tests  
Pharmacy/prescription drugs  
Cost of care co-payments  
Medicare Part B  
Third Party Liability  
Allowability

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**Thomas Randall**  
Senior Auditor

IBNR - MECMS/MFASIS reconciliation  
IT Testing - Oracle Financials  
Matching - Certified Seed  
Fraud Investigation Recovery Unit - Recipient Fraud  
Targeted Case Management  
Quality Assurance Testing  
COGNOS queries

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**Amanda Spencer, CISA**  
Senior Auditor

Eligibility - Medicaid & SCHIP  
IT Testing - Eligibility Systems:  
ACES, MACWIS, WELFRE interface to  
payment systems and related roles:  
MECMS, CNSI  
  
IT Contract Reviews - ACES, WELFRE, MECMS  
Case File Reviews - Eligibility

